PER

The New York
Academy of Medicine

By Exchange

PI

Digitized by the Internet Archive
in 2016

https://archive.org/details/journalofmedical572unse_0

TRANSACTIONS ISSUE

THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

Entered as second-class matter September 5, 1906, at the post office at Orange, New Jersey, under Act of March 3, 1879
Second Class Postage Paid at Orange, N. J.

Vol. 57, No. 7 | July, 1960 | Subscriptions, $3.00 per Year
Single Copies, 30 Cents

THE N. Y. ACADEMY OF MEDICINE
JUL 22 1960
LIBRARY

CONTENTS—Pages 345 to 448

EDITORIAL— Page

Shipment of Laboratory Animals 345

STATE ACTIVITIES—

Delegates' Action on Blue-Cross, Blue-Shield Rider 346

Trustees' Meeting: April 24, 1960 346

Examination of School Children by Family M.D. 350

Scientific Exhibit Awards 351

Attendance at 1960 Annual Meeting 351

Supplementary List No. 5 to the 1959-60 Membership Directory 352

Page

COUNTY SOCIETY REPORTS 353

OBITUARIES 354

TRANSACTIONS OF THE HOUSE OF DELEGATES—

Index 356

Annual Reports 357

Resolutions 410

Medical Service Administration 424

Medical-Surgical Plan 427

Reference Committee Reports 432

Nominations and Election 444

President Bowers' Address 447

Roster of Officers and Committee Chairmen, Advertising Page 3A

Place of Publication, Printing and Mailing, 116-118 Lincoln Ave., Orange, N. J.

Editorial and Executive Offices of the Society 315 West State St., Trenton 8, N. J.

Address all communications FOR PUBLICATION to editorial office at P.O. Box 904, Trenton 5, N. J.

Telephone EXport 4-3154

Published Monthly Since 1904

Acceptance for mailing at special rate of postage provided for in Sec. 1103, Act of Oct. 3, 1917, authorized July 29, 1918.

Copyright 1960 by
The Medical Society of New Jersey

State Medical Society Plans of Accident and Health Insurance Providing Coverage Up to $1,000 Monthly

THE MEDICAL SOCIETY OF NEW JERSEY officially selected the NATIONAL CASUALTY COMPANY in 1933 to underwrite its exclusively recognized group plan of accident and health insurance and officially selected the NATIONWIDE MUTUAL INSURANCE COMPANY in 1958 to underwrite its **additional** plan of accident and health insurance. Applications are invited from Society members who have not as yet applied; policies are available to applicants in accordance with Company rules and regulations for acceptance of risks.

BRIEF OUTLINE OF COVERAGE
NATIONAL CASUALTY COMPANY PLAN

(THE COMPLETE TERMS OF THE INSURANCE COVERAGE ARE SET FORTH IN THE POLICY)

ACCIDENTAL BODILY INJURY BENEFITS —Full monthly benefit for total disability, from FIRST DAY, limit 60 months. One-half monthly benefit for partial disability, limit 6 months. Limit of time for total and partial combined 60 months. (Total disability coverage extendable to lifetime.†)

SICKNESS BENEFITS —Full monthly benefit for total disability commencing with EIGHTH DAY of disability, limit 24 months, house confinement not required. (Total disability coverage extendable to 7 years.†)

(Regular care and attendance by a legally qualified physician or surgeon, other than yourself, required during period of disability.)

CONDITIONS OF RENEWABILITY —Once issued, the policy cannot be ridered for recurrent disability nor can it be terminated so long as the Society plan is in existence, except for non-payment of premium, if the insured retires or ceases to be actively engaged in the medical profession, if he ceases to be an active member of The Medical Society of New Jersey, or if renewal is refused on all policies issued to all members of the society, in which event 60 days prior notice in writing must be given.

EXCEPTIONS —Injury due to the hazards of warfare; suicide or intentionally self-inflicted injury, or any attempt thereat, while sane or insane; air travel, except passenger air travel as provided in the policy; all are not covered.

ANNUAL PREMIUM RATES*

(Applicable to ages at entry and attained at annual renewal of insurance)

Monthly Benefits	Dismemberment Benefits	Ages up to 50 Next Birthday	Ages 51 to 60 Next Birthday	Ages 61 to 65** Next Birthday
$100.00	$ 5,000	$ 29.50	$ 34.00	$ 43.00
150.00	7,500	43.60	50.35	63.85
200.00	10,000	57.70	66.70	84.70
300.00	15,000	85.90	99.40	126.40
400.00	20,000	114.10	132.10	168.10
500.00	20,000	141.30	163.80	208.80
‡ 600.00	20,000	168.50	195.50	249.50

* Premiums may be paid half-yearly or quarterly, pro-rata.

* All rates above INCLUDE $1000 Accidental Death Benefit.

** Although the age limit for acceptance of risks is the 65th birthday, once issued there is no termination age limit for renewal.

† Extension of sickness benefits to seven years and accident benefits for life available to holders of the above policy under age 60, in accordance with the company's underwriting regulations, through the EXTENDED PROFESSIONAL DISABILITY POLICY which is renewable to the 65th birthday. Ask about its coverage and modest additional cost.

‡ **ADDITIONAL BASIC COVERAGE UP TO $400 MONTHLY AVAILABLE THROUGH THE OFFICIALLY APPROVED NATIONWIDE MUTUAL INSURANCE COMPANY WITH SIMILAR RATES AND COVERAGE AND WHICH IS RENEWABLE TO AGE 70. Full details on all plans sent on request.**

NATIONAL CASUALTY COMPANY
through
E. and W. BLANKSTEEN

NATIONWIDE MUTUAL INSURANCE CO.
through
E. and W. BLANKSTEEN AGENCY, Inc.

75 MONTGOMERY STREET **DELAWARE 3-4340** **JERSEY CITY 2, N. J.**

LIBRARY
MAY -8 1961
335540
NEW YORK ACADEMY OF MEDICINE

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766

PLACE OF PUBLICATION, PRINTING AND MAILING, 116 LINCOLN AVE., ORANGE, N. J.

EXECUTIVE AND EDITORIAL OFFICES, 315 WEST STATE STREET, TRENTON 8, N. J. Tel. EXport 4-3154

(MAILING ADDRESS: P.O. BOX 904, TRENTON 5, N. J.)

Mr. Richard I. Nevin, *Executive Officer* ..... Trenton
Mrs. Edith L. Madden, *Administrative Secretary and Convention Manager* ..... Trenton
Henry A. Davidson, *Editor* ..... Cedar Grove
Mrs. Miriam N. Armstrong, *Assistant Editor* ..... Trenton

OFFICERS

President, Jesse McCall ..... Newton
President-Elect, Ralph M. L. Buchanan ..... Phillipsburg
First Vice-President, Louis S. Wegryn ..... Elizabeth
Second Vice-President, Carl N. Ware ..... Shiloh
Secretary, Marcus H. Greifinger ..... Newark
Treasurer, Daniel F. Featherston ..... Asbury Park

TRUSTEES

Luke A. Mulligan, *Chairman* (1962) ..... Leonia
Jerome G. Kaufman, *Secretary* (1961) ..... Newark
Jesse McCall ..... Newton
Ralph M. L. Buchanan ..... Phillipsburg
Louis S. Wegryn ..... Elizabeth
Carl N. Ware ..... Shiloh
Marcus H. Greifinger ..... Newark
Daniel F. Featherston ..... Asbury Park
F. Clyde Bowers ..... Mendham
David B. Allman (1962) ..... Atlantic City
John J. Bedrick (1963) ..... Bayonne
Nicholas A. Bertha (1962) ..... Wharton
C. Byron Blaisdell (1961) ..... Asbury Park
Louis K. Collins (1961) ..... Glassboro
Lloyd A. Hamilton (1962) ..... Lambertville
Frank J. Hughes (1963) ..... Gloucester
Joseph R. Jehl (1963) ..... Clifton
Samuel J. Lloyd (1963) ..... Trenton

COUNCILORS

First District (Union, Warren, Morris and Essex Counties) ..... Emanuel M. Satulsky, Elizabeth (1963)
Second District (Sussex, Bergen, Hudson and Passaic Counties) ..... John L. Olpp, Englewood (1962)
Third District (Mercer, Middlesex, Somerset and Hunterdon Counties) ..... Charles H. Calvin, Perth Amboy (1961)
Fourth District (Camden, Burlington, Ocean and Monmouth Counties) ..... E. Vernon Davis, Moorestown (1963)
Fifth District (Cape May, Cumberland, Atlantic, Gloucester and Salem Counties) ..... Isaac N. Patterson, Westville (196_)

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Delegates

C. Byron Blaisdell (1960) ..... Asbury Park
William F. Costello (1961) ..... Dover
Aldrich C. Crowe (1961 ..... Ocean City
J. Wallace Hurff (1960) ..... Newark
L. Samuel Sica (1960) ..... Trenton
Elmer P. Weigel (1960) ..... Plainfield

Alternates

Ralph M. L. Buchanan (1960) ..... Phillipsburg
Joseph P. Donnelly (1961) ..... Jersey City
Elton W. Lance (1961) ..... Rahway
Jesse McCall (1960) ..... Newton
Herschel Pettit (1960) ..... Ocean City
John H. Rowland (1960) ..... New Brunswick

DELEGATES TO OTHER STATES

New York—William F. Costello (1961) ..... Dover
Connecticut—Lloyd A. Hamilton (1961) ..... Lambertville
New York—Levi M. Walker (1961) ..... Atlantic City
Connecticut—S. Eugene Daiton (1961) ..... Ventnor

COMMITTEE CHAIRMEN — 1960-61

Annual Meeting ..... Jerome G. Kaufman, Newark
..... Vice-Chairman—Edward E. P. Seidmon, Plainfield
Cancer Control ..... John L. Olpp, Englewood
Child Health ..... Robert E. Jennings, South Orange
Chronically Ill and Aging ..... William H. Hahn, Newark
Constitution and Bylaws ..... Louis F. Albright, Spring Lake
..... Vice-Chairman—Joseph M. Gannon, Plainfield
Credentials ..... M. H. Greifinger, Newark
..... Vice-Chairman—Eugene J. Tyrrell, Perth Amboy
Disaster Medical Services ..... R. Winfield Betts, Medford
Finance and Budget ..... David B. Allman, Atlantic City
..... Vice-Chairman—Carl N. Ware, Shiloh
Hearing and Speech ..... S. Eugene Dalton, Ventnor
Honorary Membership ..... Aldrich C. Crowe, Ocean City
..... Vice-Chairman—Royal A. Schaaf, Clifton
Industrial Health ..... Willis B. Mitchell, Toms River
Legislation ..... C. Byron Blaisdell, Asbury Park
..... Vice-Chairman—A. Guy Campo, Westville
Maternal and Infant Welfare ..... John D. Preece, Trenton
Medical Defense and Insurance ..... Daniel F. Featherston, Asbury Park
..... Vice-Chairman—Benjamin F. Slobodien, Perth Amboy
Medical Education ..... Sherman Garrison, Jr., Bridgeton
..... Vice-Chairman—Morris H. Saffron, Passaic
Medical Services ..... Irving Klompus, Bound Brook
..... Vice-Chairman—Nicholas E. Marchione, Vineland
Medical Student Loan Fund ..... Luke A. Mulligan, Leonia
..... Vice-Chairman—Vincent P. Butler, Jersey City
Mental Health ..... John J. Mackin, Jersey City
Physicians Placement Service ..... Samuel J. Lloyd, Trenton
Publication ..... Fred B. Rogers, Trenton
..... Vice-Chairman—C. Spencer Davison, Salem
Public Health ..... Robert S. Garber, Belle Mead
..... Vice-Chairman—John B. Fuhrmann, Flemington
Public Relations ..... John F. Kustrup, Trenton
..... Vice-Chairman—John J. Torppey, Newark
Rehabilitation ..... Elmer J. Elias, Trenton
Scientific Exhibit ..... Milton Ackerman, Atlantic City
Scientific Program ..... Edward E. P. Seidmon, Plainfield
Traffic Safety ..... A. M. K. Maldeis, Camden
Vision ..... Samuel M. Diskan, Atlantic City
Woman's Auxiliary ..... Lewis C. Fritts, Somerville
..... Vice-Chairman—A. Guy Campo, Westville
Workmen's Compensation ..... Joseph A. Lepree, Elizabeth

no irritating crystals[1] · uniform concentration in each drop[2]

STERILE OPHTHALMIC SOLUTION

NEO-HYDELTRASOL®

PREDNISOLONE 21-PHOSPHATE-NEOMYCIN SULFATE

2,000 TIMES MORE SOLUBLE THAN PREDNISOLONE OR HYDROCORTISONE

"The solution of prednisolone has the advantage over the suspension in that no crystalline residue is left in the patient's cul-de-sac or in his lashes . . . . The other advantage is that the patient does not have to shake the drops and is therefore sure of receiving a consistent dosage in each drop."[2]

1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

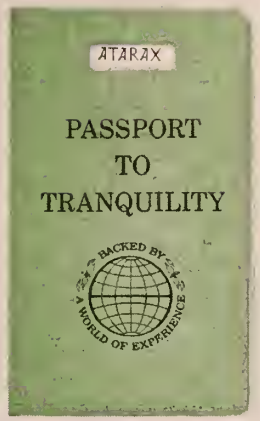
supplied: 0.5% Sterile Ophthalmic Solution NEO-HYDELTRASOL (with neomycin sulfate) and 0.5% Sterile Ophthalmic Solution HYDELTRASOL®. In 5 cc. and 2.5 cc. dropper vials. Also available as 0.25% Ophthalmic Ointment NEO-HYDELTRASOL (with neomycin sulfate) and 0.25% Ophthalmic Ointment HYDELTRASOL. In 3.5 Gm. tubes.

HYDELTRASOL and NEO-HYDELTRASOL are trademarks of Merck & Co., Inc.

MSD MERCK SHARP & DOHME Division of Merck & Co., Inc., Philadelphia 1, Pa.

A GUIDE TO

THE REALMS OF THERAPY BEST ATTAINED WITH



ATARAX®

(brand of hydroxyzine)

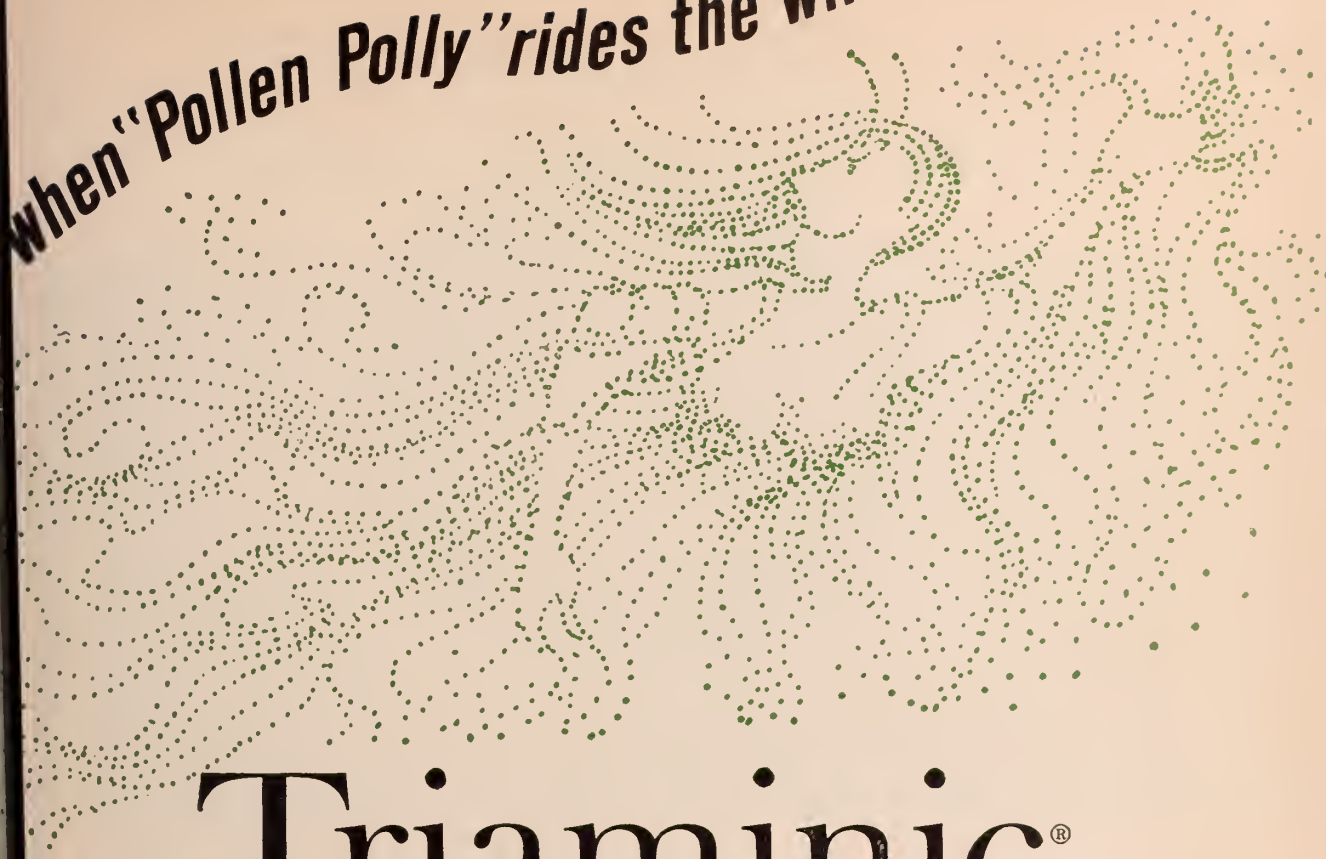
World-wide record of effectiveness—over 200 laboratory and clinical papers from 14 countries.
Widest latitude of safety and flexibility—no serious adverse clinical reaction ever documented.
Chemically distinct among tranquilizers—not a phenothiazine or a meprobamate.
Added frontiers of usefulness—antihistaminic; mildly antiarrhythmic; does not stimulate gastric secretion.

Special Advantages	Supportive Clinical Observation	...and for additional evidence
IN CHILDREN unusually safe; tasty syrup, 10 mg. tablet	"...Atarax appeared to reduce anxiety and restlessness, improve sleep patterns and make the child more amenable to the development of new patterns of behavior...." Freedman, A. M.: Pediat. Clin. North America **5**:573 (Aug.) 1958.	Bayart, J.: Acta paediat. belg. **10**:164, 1956. Ayd, F. J., Jr.: California Med. **87**:75 (Aug.) 1957. Nathan, L. A., and Andelman, M. B.: Illinois M. J. **112**:171 (Oct.) 1957.
IN ELDERLY PATIENTS well tolerated by debilitated patients	"...seems to be the agent of choice in patients suffering from removal disorientation, confusion, conversion hysteria and other psychoneurotic conditions occurring in old age." Smigel, J. O., et al.: J. Am. Geriatrics Soc. **7**:61 (Jan.) 1959.	Settel, E.: Am. Pract. & Digest Treat. **8**:1584 (Oct.) 1957. Negri, F.: Minerva med. **48**:607 (Feb. 21) 1957. Shalowitz, M.: Geriatrics **11**:312 (July) 1956.
IN ALLERGIC PATIENTS useful adjunctive therapy for asthma and dermatosis; particularly effective in urticaria	"All [asthmatic] patients reported greater calmness and were able to rest and sleep better...and led a more normal life....In chronic and acute urticaria, however, hydroxyzine was effective as the sole medicament." Santos, I. M., and Unger, L.: Presented at 14th Annual Congress, American College of Allergists, Atlantic City, New Jersey, April 23-25, 1958.	Eisenberg, B. C.: J.A.M.A. **169**:14 (Jan. 3) 1959. Coirault, R., et al.: Presse méd. **64**:2239 (Dec. 26) 1956. Robinson, H. M., Jr., et al.: South. M. J. **50**:1282 (Oct.) 1957.
IN HYPEREMOTIVE ADULTS does not impair mental acuity	"...especially well-suited for ambulatory neurotics who must work, drive a car, or operate machinery." Ayd, F. J., Jr.: New York J. Med. **57**:1742 (May 15) 1957.	Garber, R. C., Jr.: J. Florida M. A. **45**:549 (Nov.) 1958. Menger, H. C.: New York J. Med. **58**:1684 (May 15) 1958. Farah, L.: Internat. Rec. Med. **169**:379 (June) 1956.

SUPPLIED: Tablets, 10 mg., 25 mg., 100 mg.; bottles of 100. Syrup (10 mg. per tsp.), pint bottles. Parenteral Solution: 25 mg./cc. in 10 cc. multiple-dose vials; 50 mg./cc. in 2 cc. ampules.

New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being

When "Pollen Polly" rides the wind...



Triaminic®

...relief from pollen allergies

more complete than antihistamines alone... more thorough than nose drops or sprays

The miseries of respiratory allergy can be relieved so effectively with Triaminic.[1-5] Triaminic contains two antihistamines plus the decongestant, phenylpropanolamine, to help shrink the engorged capillaries, reduce congestion and bring relief from rhinorrhea and sinusitis.[1] Oral administration distributes medication to *all* respiratory membranes without risk of "nose drop addiction" or rebound congestion.[2,3]

Each Triaminic timed-release Tablet provides:

Phenylpropanolamine HCl	50 mg.
Phenlramine maleate	25 mg.
Pyrilamine maleate	25 mg.

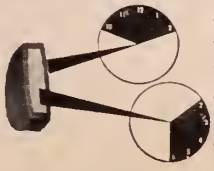
also available:

TRIAMINIC JUVELETS® ½ the formulation of the Triaminic Tablet with timed-release action.

TRIAMINIC SYRUP each teaspoonful (5 ml.) provides ¼ the formulation of the Triaminic Tablet.

References: 1. Fabricant, N. D.: E. E. N. T. Monthly 37:460 (July) 1958. 2. Lhotka, F. M.: Illinois M. J. 112:259 (Dec.) 1957. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958. 4. Fuchs, M.; Bodi, T.; Mallen, S. R.; Hernando, L., and Moyer, J. H.: Antibiotic Med. & Clin. Ther. 7:37 (Jan.) 1960. 5. Halpern, S. R., and Rabinowitz, H.: Ann. Allergy 18:36 (Jan.) 1960.

Relief is prompt and prolonged because of this special timed-release action



first—the outer layer dissolves within minutes to produce 3 to 4 hours of relief

then—the core disintegrates to give 3 to 4 more hours of relief

SMITH-DORSEY • A DIVISION OF THE WANDER COMPANY • LINCOLN, NEBR.

AN AMES CLINIQUICK®

CLINICAL BRIEFS FOR MODERN PRACTICE

WHAT LABORATORY PROCEDURES ARE INDICATED IN DIABETICS WITH URINARY TRACT INFECTIONS?

A urine culture is absolutely essential in the diabetic suspected of having a urinary tract infection since such infection is not always accompanied by pyuria. It is also essential to keep the urine free from sugar—as shown by frequent urine-sugar tests—for successful therapy.

Source: Harrison, T. R., *et al.:* Principles of Internal Medicine, ed. 3, New York, McGraw-Hill Book Co., 1958, p. 620.

the most effective method of routine testing for glycosuria...

color-calibrated

CLINITEST®

BRAND *Reagent Tablets*

the *standardized* urine-sugar test for reliable quantitative estimations

Urinary tract infections are about four times more frequent in the diabetic than in the non-diabetic. The prevention and treatment of urinary tract infections, as well as the avoidance of other complications of diabetes, are significantly more effective in the well-controlled diabetic. The patient should be impressed repeatedly with the importance of continued daily urine-sugar testing—especially during intercurrent illness—and warned of the consequences of relaxed vigilance.

"urine-sugar profile" With the new *Graphic Analysis Record* included in the CLINITEST Urine-Sugar Analysis Set (and in the tablet refills), daily urine-sugar readings may be recorded to form a graphic portrayal of glucose excretion most useful in clinical control.

- *motivates patient cooperation* through everyday use of Analysis Record
- *reveals at a glance day-to-day trends* and degree of control
- *provides a standardized color scale* with a complete range in the familiar blue-to orange spectrum

84460

AMES
COMPANY, INC
Elkhart • Indiana
Toronto • Canada

guard against ketoacidosis
...test for ketonuria
for patient and physician use

ADDED SAFETY FOR DIABETIC CHILDREN

ACETEST® *Reagent Tablets* **KETOSTIX®** *Reagent Strips*

in antacid therapy...
patient cooperation is half the battle

Are you chancing unsatisfactory results because the patient doesn't like the taste of the antacid you have prescribed? Assure patient cooperation. Prescribe the antacid which assures patient acceptance through its excellent palatability.

'Palatable Margel'

unsurpassed in performance
unequalled in palatability

antacid suspension/tablets

MARGEL is a highly palatable formulation of four antacids: selected aluminum hydroxides, magnesium hydroxide, magnesium trisilicate and calcium carbonate. Balanced to be non-constipating; formulated to be non-chalky. Write for a sample and see for yourself.

Supplied: Margel Suspension — bottles of 12 fluid ounces. Margel Tablets — boxes of 96.
Dosage: SUSPENSION: 1 tablespoonful 20 minutes after meals and on retiring. May be taken with milk if desired. TABLETS: 2 or more tablets 20 minutes after meals and on retiring. May be chewed or allowed to dissolve slowly in the mouth.

MRT *M. R. Thompson, Inc.* CRANFORD, N. J.

STEREO WEBCOR

WEBCOR REGENT CORONET STEREO HI-FI TAPE RECORDER

$329.95

- Will record and play back bath stereo and manaural tapes
- Pravides 2-channel and 4-channel sterea playback
- Dual-channel 16-watt amplifier
- Self-contained Stereo system with 2 Hi-Fi Speakers
- 2 directianal micraphones
- In ebony with silver trim

Model 2007

Available at all

DEPT. STORES AND BETTER MUSIC, RECORD, CAMERA AND APPLIANCE DEALERS

Write for catalog to Exclusive N. J. Wholesale Distributors

ALL-STATE DISTRIBUTORS,

INCORPORATED

457 CHANCELLOR AVENUE **NEWARK, N. J.**

in arthritis and allied disorders

Butazolidin®

brand of phenylbutazone

Geigy

Proved by a Decade of Experience
Confirmed by 1700 Published Reports
Attested by World-Wide Usage

Since its anti-inflammatory properties were first noted in Geigy laboratories 10 years ago, time and experience have steadily fortified the position of Butazolidin as a leading nonhormonal anti-arthritic agent. Indicated in both chronic and acute forms of arthritis, Butazolidin is noted for its striking effectiveness in relieving pain, increasing mobility and halting inflammatory change.

Butazolidin®, brand of phenylbutazone: Red, sugar-coated tablets of 100 mg. Butazolidin® Alka: Orange and white capsules containing Butazolidin 100 mg.; dried aluminum hydroxide gel 100 mg.; magnesium trisilicate 150 mg.; homatropine methylbromide 1.25 mg.

Geigy, Ardsley, New York

162-60

MENNEN BABY MAGIC
Actually prevents
and heals diaper rash!

A THREE-HANDED ASSISTANT...

MENNEN BABY OIL
A better, safer cleanser
than soap!

IN THE FIGHT AGAINST DIAPER RASH!

MENNEN BABY POWDER
It's wet-resistant; protects
babies better against
diaper rash, chafing!

MENNEN... Baby Specialist since 1880

by the time you read this 500,000 patients* will have been treated with

Altafur®

brand of furaltadone

a "first choice" antimicrobial

In the 10 months since its introduction, ALTAFUR has effected cures in 75 per cent and improvement in an additional 15 per cent of recorded† cases. These cases included:

■ respiratory infections ■ wound infections ■ pyoderma ■ abscess ■ E.E.N.T. infections ■ bacteremia ■ osteomyelitis

Altafur is orally effective against the vast majority of common infections caused by pathogenic bacteria—including antibiotic-resistant staphylococci

■ therapeutic success is outstanding ■ *development of significant bacterial resistance is seldom—if ever—encountered* ■ normal intestinal flora is not unfavorably affected ■ monilial overgrowth has never been reported

For a better index of therapeutic success use Altafur

Tablets of 250 mg. (adult) and 50 mg. (pediatric), bottles of 20 and 100.

Average adult dose: 250 mg. four times a day. Pediatric dosage: 22-25 mg./Kg. (10-11.5 mg./lb.) body weight daily in 4 divided doses. Each dose should be taken with meals, and with food or milk at bedtime. *Alcohol should not be ingested in any form, medicinal or beverage, during* ALTAFUR *therapy and for one week thereafter.*

*Based on a projection of ALTAFUR Tablets dispensed in 10 months since their introduction.

†Compiled by the Medical Department, Eaton Laboratories, from case histories received.

NITROFURANS—a *unique* class of antimicrobials

EATON LABORATORIES, NORWICH, NEW YORK

"The concept of treating hypertension with a potent oral diuretic in combination with one or more of the sympathetic depressant drugs is a new one."[1]

GENTLEMEN: Please send me a complimentary supply of SALUTENSIN Tablets.

DR._____

STREET_____

CITY_____ZONE_____STATE_____

SIGNATURE_____

Send coupon to: BRISTOL LABORATORIES, SYRACUSE, NEW YORK.

SALUTENSIN samples available on request.

REFERENCES: **1.** Gifford, R. W., Jr., *In* Hypertension, ed. by J. H. Moyer, Saunders, Philadelphia, 1959, p. 561. **2.** Moyer, J. H.: *Ibid.* p. 299. **3.** Brodie, B. B.: *In* Hypertension, Vol. VII, Proceedings Council for High Blood Pressure Research, Am. Heart Assn., ed. by F. R. Skelton, 1959, p. 82. **4.** Wilkins, R. W.: Ann. Int. Med. 50:1, 1959. **5.** Freis, E. D.: *In* Hypertension, ed. by Moyer, *op. cit.*, p. 123. **6.** Ford, R. V., and Nickell, J.: Ant. Med. & Clin. Ther. 6:461, 1959. **7.** Fuchs, M., and Mallin, S. R.: Int. Red. Med. 172:438, 1959.

NEW

For the "multi-system disease"[2] HYPERTENSION...
an integrated multi-therapeutic antihypertensive...

SALUTENSIN™

Hydroflumethiazide • Reserpine • Protoveratrine A

A multi-system disease such as essential hypertension often requires a multi-therapeutic approach for satisfactory control. SALUTENSIN combines in balanced proportions three clinically proven antihypertensives. These components act through three different physiologic mechanisms to offer greater therapeutic benefits while minimizing the risk of side effects sometimes observed in patients on single drug therapy at maximally effective doses. The components in each SALUTENSIN Tablet

SALURON (hydroflumethiazide Bristol) — a saluretic-antihypertensive agent postulated to lower elevated blood pressure by affecting vascular reactivity to a still unknown pressor mechanism ..... 50 mg.

Reserpine — a tranquilizing drug with peripheral vasodilatant effects, which have been described as a "chemical sympathectomy" ..... 0.125 mg

Protoveratrine A — a potent hypotensive drug[3] which is "well tolerated" in combination with rauwolfia[4] a centrally mediated vasodilatant that produces "the most physiologic, hemodynamic reversal of hypertension"[5]....0.2 mg.

INDICATIONS: Essential hypertension; hypertensive cardiovascular disease; insufficient response to a single or dual antihypertensive agent; partial or complete replacement of potentially more toxic agents.

SALUTENSIN should be used cautiously in hypertensive patients with renal insufficiency, particularly if such patients are digitalized.

DOSAGE: Usual adult dose 1 tablet twice daily. Detailed information on dosage and precautions in official package circular or available on request.

SUPPLY: Bottles of 60 scored tablets.

A sustained-action foundation drug for an antihypertensive regimen . . .

saluron®

sustained-action hydroflumethiazide 'Bristol'

SALURON is an economical, well-tolerated *salutensive* agent — saluretic and antihypertensive — for use as a foundation drug in the treatment of hypertension. In mild to moderate hypertension, SALURON often is adequate by itself. It has been described as "a distinct advantage in the manifestations of hypertension"[6] and "a marked advancement in the field of diuretic therapy."[7]

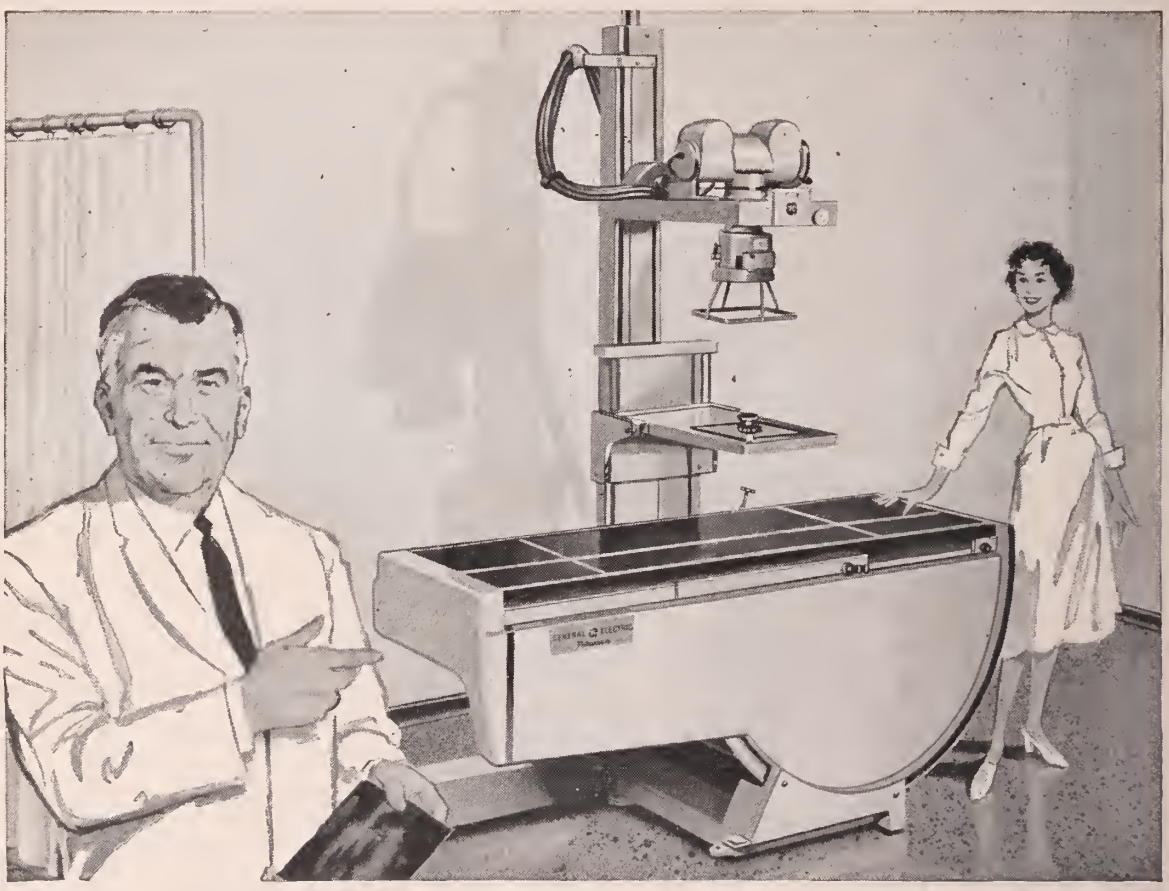
DOSAGE: Usually 1 tablet daily. Full information in official package circular.

SUPPLY: Scored 50-mg. tablets, bottles of 50.

Bristol

BRISTOL LABORATORIES, Syracuse, New York

The choice of confidence...



diagnostic x-ray equipment planned for private practice!

Few who purchase x-ray equipment have time to thoroughly test the quality of materials, workmanship and technical performance offered by all the makes of x-ray units. And happily this is not necessary.

The manufacturer's *reputation* is worth more than anything else to you in choosing x-ray equipment, one of the most complex professional investments you will ever face.

General Electric has created "just what the doctor ordered" in the 200-ma Patrician, in terms of both reasonable cost and operating qualities. Here diagnostic x-ray is ideally tailored to *private practice.* Patrician provides everything you need for radiography and fluoroscopy — and with consistent end results, since precise radiographic calibration is as much a part of the Patrician combination as it is of our most elaborate installations. For complete details contact your G-E x-ray representative listed below.

Progress Is Our Most Important Product

GENERAL ELECTRIC

DIRECT FACTORY BRANCHES

NEWARK
Springfield—52 Commerce St. • DRexel 9-4865

PHILADELPHIA
Hunting Pk. Ave. at Ridge • BAldwin 5-7600

1¼ Grs. Ea.
FLAVORED

Living up to a family tradition

There are probably certain medications which are special favorites of yours, medications in which you have a particular confidence.

Physicians, through ever increasing recommendation, have long demonstrated their confidence in the uniformity, potency and purity of Bayer Aspirin, the world's first aspirin.

And like Bayer Aspirin, Bayer Aspirin for Children is quality controlled. No other maker submits aspirin to such thorough quality controls as does Bayer. This assures uniform excellence in both forms of Bayer Aspirin.

You can depend on Bayer Aspirin for Children for it has been conscientiously formulated to be the best tasting aspirin ever made and to live up to the Bayer family tradition of providing the finest aspirin the world has ever known.

Bayer Aspirin for Children—1¼ grain flavored tablets—Supplied in bottles of 50.

● We welcome your requests for samples on Bayer Aspirin and Flavored Bayer Aspirin for Children.

New GRIP-TIGHT CAP for Children's Greater Protection

THE BAYER COMPANY, DIVISION OF STERLING DRUG INC., 1450 BROADWAY, NEW YORK 18, N. Y.

A Vacation from Hay Fever is a Real Vacation

ANYWHERE – ANYTIME

Just a "poof" of fine **NTZ** *spray brings relief* IN SECONDS, FOR HOURS

NTZ is a potentiated, balanced combination of these well known synergistic compounds:

Neo-Synephrine® HCl, 0.5%
– dependable vasoconstrictor and decongestant.

Thenfadil® HCl, 0.1%
– potent topical antihistaminic.

Zephiran® Cl, 1:5000
– antibacterial wetting agent and preservative.

NTZ® NASAL SPRAY

Supplied in leakproof, pocket size squeeze bottles of 20 cc.

Winthrop LABORATORIES
New York 18, N.Y.

when pressure is a problem

Reduce pressure through bradycardic, tranquillizing action....

'Rauwistan'

the MRT-standardized Rauwolfia

BECAUSE its unique chemical and biological standardization assures uniformity and consistency of effect time after time with high activity and minimal incidence of side effects.

SUPPLIED: Tablets of 50 and 100 mg., in bottles of 100.

DOSAGE: 100 to 300 mg. daily, in divided doses.

Reduce pressure through bradycardic, tranquillizing plus direct hypotensive action....

'Verwolfia'

the MRT-standardized Rauwolfia-Veratrum

BECAUSE it adds to Rauwistan the specific hypotensive effect of uniquely standardized Veratrum and assures uniformity and consistency of effect time after time with high activity and minimal incidence of side effects.

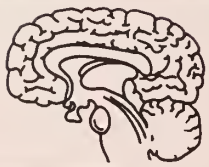
SUPPLIED: 50 mg. of Rauwolfia serpentina and of Veratrum viride (standardized whole root) in each tablet; in bottles of 50 and 100.

DOSAGE: 1 to 3 tablets daily for the first 2 or 3 days; then 1 or 2 tablets daily, as required.

MRT *M. R. Thompson, Inc.* Cranford, N. J.

basic in the care of the aging

℞ Metalex®



when body tone, mental and sensory faculties begin to fade—*she's irritable, confused, forgetful, apathetic*

when vision begins to dim—*in loss of visual acuity, in loss of peripheral vision*

when voices begin to fade—*in loss of auditory acuity, in tinnitus*

Metalex® *cerebral stimulant/vasodilator*

The stimulant—pentylenetetrazol—facilitates cerebral and reflex nerve activity.

The vasodilator—nicotinic acid—augments blood and oxygen supply to vital areas—

Thus, METALEX increases body tone and aids mental and sensory faculties.

Composition: Each teaspoonful (5 ml.) of the Elixir and each Tablet contains: Pentylenetetrazol 100 mg., Nicotinic Acid 50 mg.

Dosage: One or two teaspoonfuls of the Elixir or one or two Tablets four times a day—one-half hour before meals and before bedtime.

Available: Elixir: Pint and Gallon bottles. Tablets: Bottles of 100 and 1000.

References: 1. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics, 2nd Ed., New York, Macmillan Company, 1955. 2. O'Reilly, P. O., Demay, M. and Kotlowski, K.: Cholesteremia and Nicotinic Acid. A.M.A. Arch. Int. Med. 100:797-801 (Nov.) 1957.

STORCK Pharmaceuticals, Inc.,
2326 Hampton Blvd., St. Louis 10, Mo.

THE ORIGINAL potassium phenethicillin

SYNCILLIN®

(Potassium Penicillin-152)

BRISTOL

higher peak blood levels
than with potassium penicillin V

higher initial peak blood levels *orally*
than with intramuscular penicillin G

increased dosage increases
serum levels proportionally

superior to other penicillins
in killing many staph strains *in vitro*

A dosage form to meet the individual
requirements of patients of all ages
in home, office, clinic and hospital:

Syncillin Tablets—250 mg. . . . Syncillin Tablets—125 mg.
Syncillin for Oral Solution—60 ml. bottles—when reconstituted, 125 mg. per 5 ml.
Syncillin Pediatric Drops —1.5 Gm. bottles. Calibrated dropper delivers 125 mg.

Complete information on indications, dosage and precautions is included in the official circular accompanying each package.

BRISTOL LABORATORIES, SYRACUSE, NEW YORK

in allergic and inflammatory skin disorders (including psoriasis)

unsurpassed for total corticosteroid benefits

Aris

Substantiated by published reports of leading clinicians

• **effective control** of allergic and inflammatory symptoms[1-3,7,8,12-15,17,18]

• **minimal disturbance** of the patient's chemical and psychic balance[1,4-18]

At the recommended antiallergic and anti-inflammatory dosage levels, ARISTOCORT means:

- freedom from salt and water retention
- virtual freedom from potassium depletion
- negligible calcium depletion
- euphoria and depression rare
- no voracious appetite — no excessive weight gain
- low incidence of peptic ulcer
- low incidence of osteoporosis with compression fracture

Precautions: With ARISTOCORT all traditional precautions to corticosteroid therapy should be observed. Dosage should always be carefully adjusted to the smallest amount which will suppress symptoms.

After patients have been on steroids for prolonged periods, discontinuance must be carried out gradually over a period of as much as several weeks.

Supplied: 1 mg. scored tablets (yellow); 2 mg. scored tablets (pink); 4 mg. scored tablets (white); 16 mg. scored tablets (white).

Diacetate Parenteral (for intra-articular and intrasynovial injection). Vials of 5 cc. (25 mg./cc.).

References: 1. Feinberg, S. M.; Feinberg, A. R., and Fisherman, E. W.: *J.A.M.A.* 167:58 (May 3) 1958. 2. Epstein, J. I., and Sherwood, H.: *Conn. Med.* 22:822 (Dec.) 1958. 3. Friedlaender, S., and Friedlaender, A. S.: *Antibiotic Med. & Clin. Ther.* 5:315 (May) 1958. 4. Segal, M. S., and Duvenci, J.: *Bull. Tufts N.E. Medical Center* 4:71 (April-June) 1958. 5. Segal, M. S.: Report to the A.M.A. Council on Drugs, *J.A.M.A.* 169:1063 (March 7) 1958. 6. Hartung, E. F.: *J. Florida Acad. Gen. Practice* 8:18, 1957. 7. Rein, C. R.; Fleischwager, R., and Rosenthal, A. L.: *J.A.M.A.* 165: 1821 (Dec. 7) 1957. 8. McGavack, T. H.: *Clin. Med.* (June) 1959. 9. Freyberg, R. H.; Berntsen, C. A., and Hellman, L.: *Arthritis & Rheumatism* 1:215 (June) 1958. 10. Hartung, E. F.: *J.A.M.A.* 167:973 (June 21) 1958. 11. Zuckner, J.; Ramsey, R. H.; Caciolo, C., and Gantner, G. E.: *Ann. Rheumat. Dis.* 17:398 (Dec.) 1958. 12. Appel, B.; Tye, M. J., and Leibsohn, E.: *Antibiotic Med. & Clin. Ther.* 5:716 (Dec.) 1958. 13. Kalz, F.: *Canad. M.A.J.* 79:100 (Sept.) 1958. 14. Mullins, J. F., and Wilson, C. J.: *Texas J. Med.* 54:648 (Sept.) 1958. 15. Shelley, W. B.; Harun, J. S., and Pillsbury, D. M.: *J.A.M.A.* 167:959 (June 21) 1958. 16. DuBois, E. L.: *J.A.M.A.* 167:1590 (July 26) 1958. 17. McGavack, T. H.; Kao, K. T.; Leake, D. A.; Bauer, H. G., and Berger, H. E.: *Am. J. M. Sc.* 236:720 (Dec.) 1958. 18. Council on Drugs: *J.A.M.A.* 169:257 (January) 1959.

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

SPEED

DURATION

IN *ORAL* CONTROL OF PAIN

ACTS FASTER—usually within 5-15 minutes. **LASTS LONGER**—usually 6 hours or more. **MORE THOROUGH RELIEF**—permits uninterrupted sleep through the night. **RARELY CONSTIPATES**—excellent for chronic or bedridden patients.

AVERAGE ADULT DOSE: 1 tablet every 6 hours. May be habit-forming. Federal law permits oral prescription.

Each PERCODAN* Tablet contains 4.50 mg. dihydrohydroxycodeinone hydrochloride, 0.38 mg. dihydrohydroxycodeinone terephthalate, 0.38 mg. homatropine terephthalate, 224 mg. acetylsalicylic acid, 160 mg. phenacetin, and 32 mg. caffeine.

Also available — for greater flexibility in dosage — PERCODAN®-DEMI: The PERCODAN formula with one-half the amount of salts of dihydrohydroxycodeinone and homatropine.

Endo®

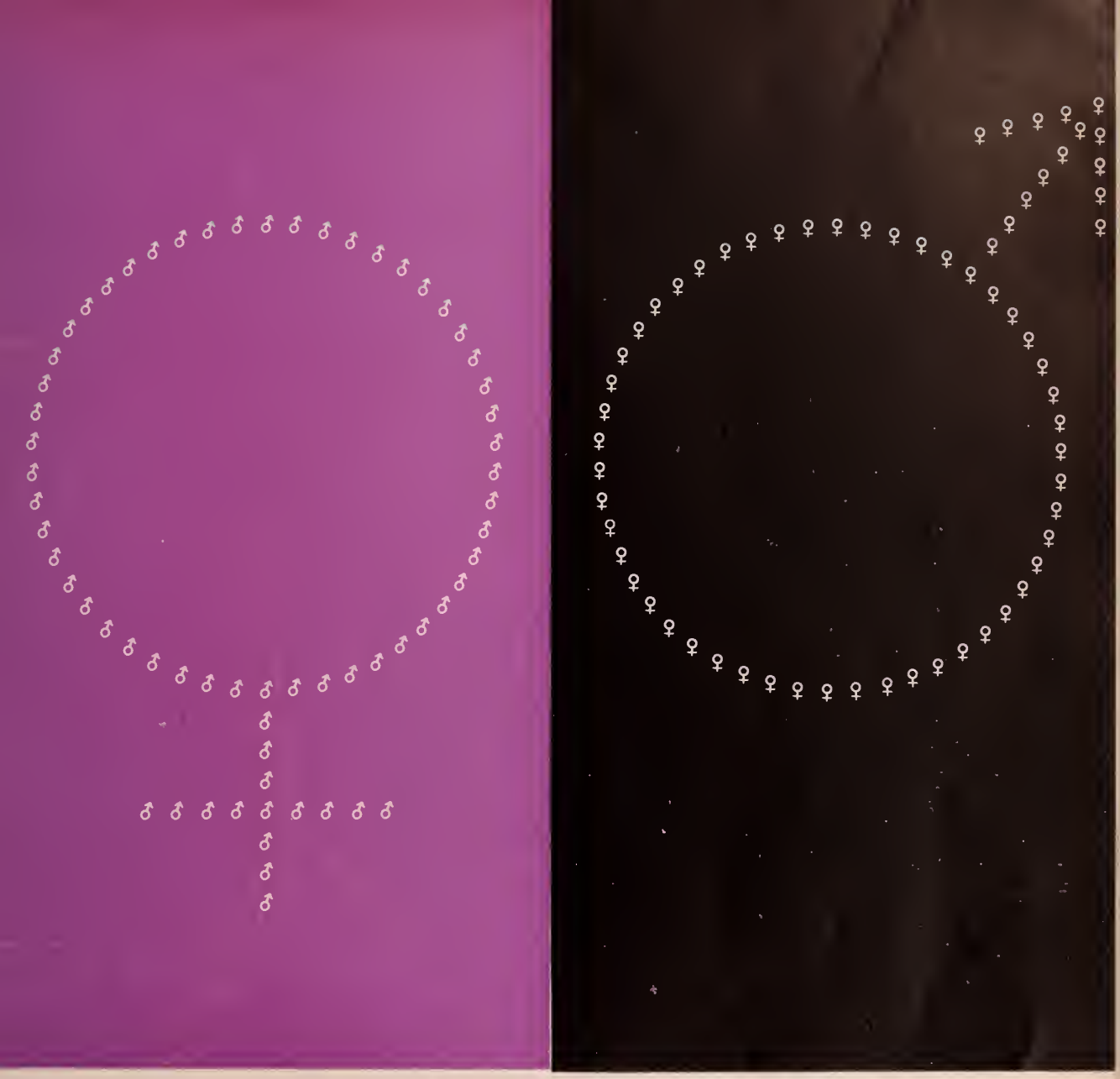
Literature? Write
ENDO LABORATORIES
Richmond Hill 18, New York

Percodan® *Tablets*

Salts of Dihydrohydroxycodeinone and Homatropine, plus APC

FOR PAIN

*U.S. Pat. 2,628,185



GONORRHEA *IS ON THE MARCH AGAIN...*

a new timetable for recovery:

only six capsules of TETREX can cure a male patient with gonorrhea in *just one day**

Tetrex®

U.S.PAT.NO.2,791,609

THE ORIGINAL TETRACYCLINE PHOSPHATE COMPLEX

TETREX CAPSULES. 250 mg. Each capsule contains: TETREX (tetracycline phosphate complex equivalent to tetracycline HCl activity) — 250 mg.

DOSAGE: Gonorrhea in the male — Six capsules of TETREX in 3 divided doses, in one day.

* Marmell, M., and Prigot, A.: Tetracycline phosphate complex in the treatment of acute gonococcal urethritis in men. Antibiotic Med. & Clin. Ther. 6:108 (Feb.) 1959.

BRISTOL

BRISTOL LABORATORIES,
SYRACUSE, NEW YORK

for relief of hypertension

RUHEXATAL WITH RESERPINE

for

Rapid and Prolonged

BLOOD PRESSURE REDUCTION

RELIEF OF ANXIETY AND TENSION

Protection Against

CAPILLARY FRAGILITY

A therapeutic combination providing a safe, effective, long range treatment of hypertension with minimal side effects high patient acceptance and economy.

Each tablet contains Reserpine 0.1 mg.
Mannitol Hexanitrate 30 mg. Rutin 20 mg.
Ascorbic Acid 10 mg.

LEMMON PHARMACAL CO. SELLERSVILLE, PA.

The One William Street Fund, Inc.

A diversified mutual fund investing selectively in securities of American business and industry with the objectives of achieving reasonable capital growth and of providing a fair and reasonable current return to share owners.

For prospectus see your investment dealer or send this coupon to

WILLIAM STREET SALES, INC. JMS
One William Street, New York 4, N. Y.

Send me a prospectus and literature on
THE ONE WILLIAM STREET FUND, Inc.

Name .....

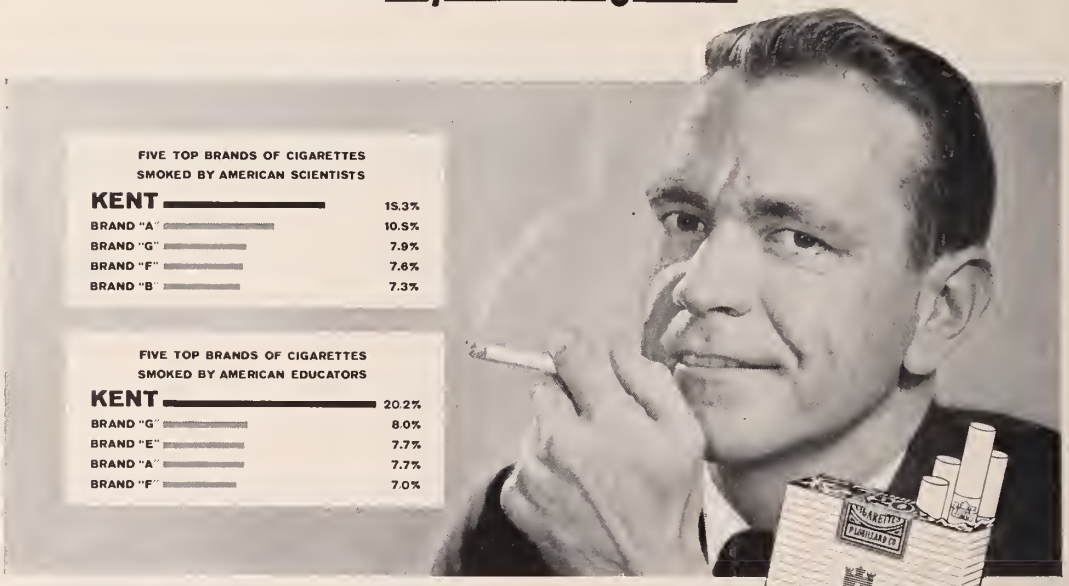
Address .....

City ..... *State* .....

ALL OVER AMERICA!

KENT with the MICRONITE FILTER IS SMOKED BY MORE SCIENTISTS and EDUCATORS

than any other cigarette!*



THIS does not constitute a professional endorsement of Kent. But these men, like millions of other Kent smokers, smoke for pleasure, and choose their cigarette accordingly.

The rich pleasure of smoking Kent comes from the flavor of the world's finest natural tobaccos, and the free and easy draw of Kent's famous Micronite Filter.

If you would like the booklet, "The Story of Kent", for your own use, write to: P. Lorillard Company—Research Department, 200 East 42nd Street, New York 17, New York.

For good smoking taste, it makes good sense to smoke KENT

* Results of a continuing study of cigarette preferences, conducted by O'Brien Sherwood Associates, N.Y., N.Y.

A PRODUCT OF P. LORILLARD COMPANY FIRST WITH THE FINEST CIGARETTES THROUGH LORILLARD RESEARCH

© 1960, P. LORILLARD CO.

When summertime chores bring on

LOW BACK PAIN

Trancopal®

Brand of chlormezanone

relaxes skeletal muscle spasm—ends disability.

When any of a host of summer activities brings on low back pain associated with skeletal muscle spasm, your patient need not be disabled or even uncomfortable. The spasm can be relaxed with Trancopal, and relief of pain and disability will follow promptly.

Lichtman[1,2] used Trancopal to treat patients with low back pain, stiff neck, bursitis, rheumatoid arthritis, osteoarthritis, trauma, and postoperative muscle spasm. He noted that Trancopal produced satisfactory relief in 817 of 879 patients (excellent results in 268, good in 448 and fair in 101).

Gruenberg[3] prescribed Trancopal for 70 patients with low back pain and observed that it brought marked improvement to all. "In addition to relieving spasm and pain, with subsequent improvement in movement and function, Trancopal reduced restlessness and irritability in a number of patients."[3] In another series, Kearney[4] reported that Trancopal produced relief in 181 of 193 patients suffering from low back pain and other forms of musculoskeletal spasm.

Trancopal enables the anxious patient to work or play. According to Gruenberg, "In addition to relieving muscle spasm in a variety of musculoskeletal and neurologic conditions, Trancopal also exerts a marked tranquilizing action in anxiety and tension states."[3] Kearney[4] found "... that Trancopal is the most effective oral skeletal muscle relaxant and mild tranquilizer currently available."

Side effects are rare and mild. "Trancopal is exceptionally safe for clinical use."[3] In the 70 patients with low back pain treated by Gruenberg,[3] the only side effect noted was mild nausea which occurred in 2 patients. In Lichtman's group, "No patient discontinued chlormethazanone [Trancopal] because of intolerance."[1]

'ow Supplied: Trancopal Caplets®
200 mg. (green colored, scored), bottles of 100.
100 mg. (peach colored, scored), bottles of 100.

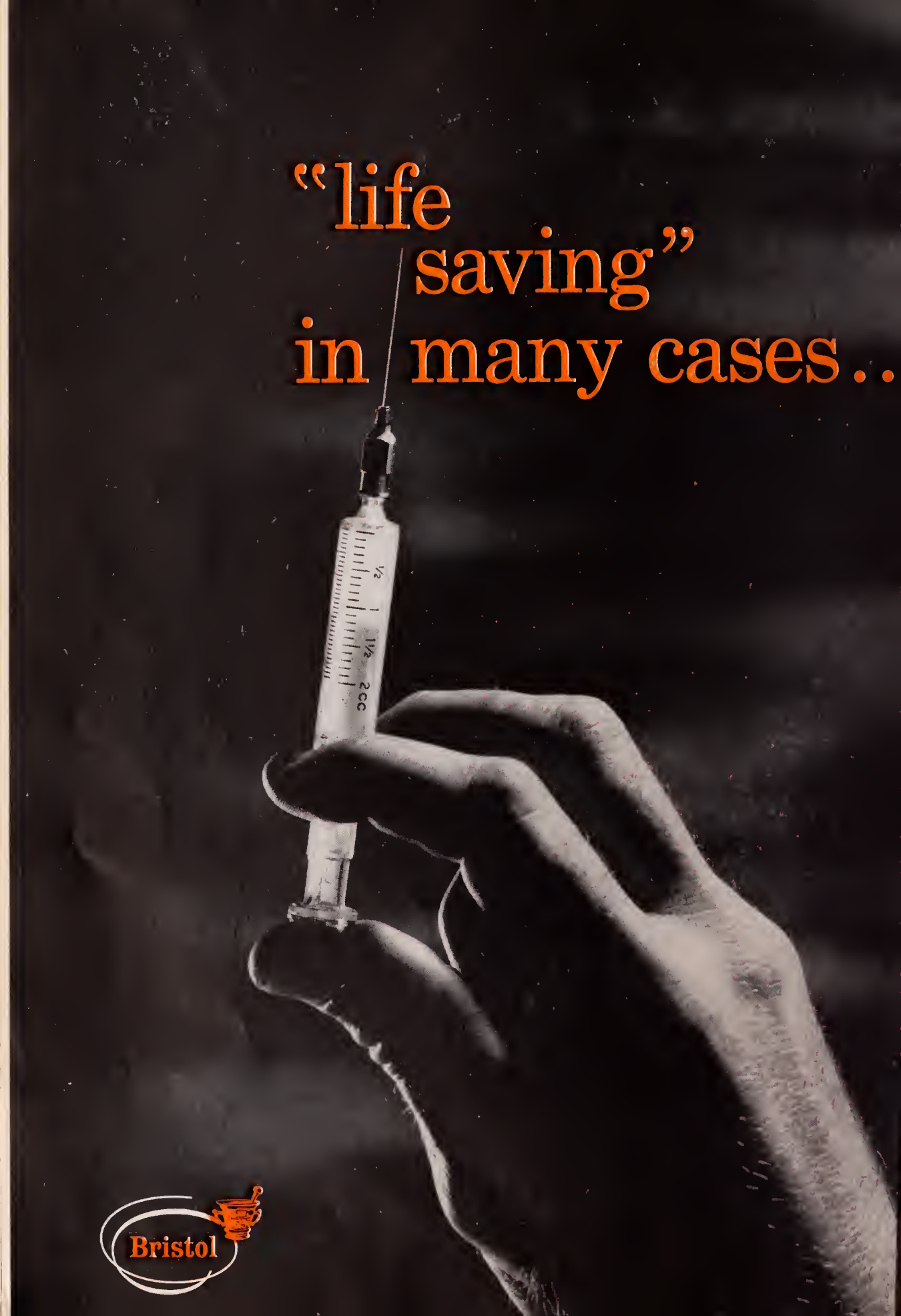
'osage: Adults, 200 or 100 mg. orally three or four mes daily. Relief of symptoms occurs in from fteen to thirty minutes and lasts from four to six ɔurs.

eferences: 1. Lichtman, A. L.: *Kentucky Acad. Gen. ract. J.* 4:28, Oct., 1958. 2. Lichtman, A. L.: Scientific xhibit, Internat. Coll. Surgeons, Miami Beach, Fla., Jan. 7, 1959. 3. Gruenberg, Friedrich: *Current Therap. Res.* 1, Jan., 1960. 4. Kearney, R. D.: *Current Therap. Res.* 127, April. 1960.

Winthrop LABORATORIES
New York 18, N.Y.

ANCOPAL (BRAND OF CHLORMEZANONE) AND CAPLETS, TRADEMARKS REG. U.S. PAT. OFF.

OOM


"life
saving"
in many cases..
Bristol

KANTREX®

INJECTION

Kanamycin Sulfate Injection

...a highly potent, bactericidal antibiotic for combating staph and gram negative infections

...well tolerated when used on a properly individualized dosage schedule which does not induce excessive blood levels

"In many instances its effect has been dramatic and life saving . . ."[1]

"Six of the patients who survived were considered to be terminally ill at the time kanamycin was started but showed dramatic improvement and eventual complete recovery."[2]

"...indeed, the results [with kanamycin] are the most remarkable ever achieved with otherwise fatal staphylococcal infections that we have ever seen."[3]

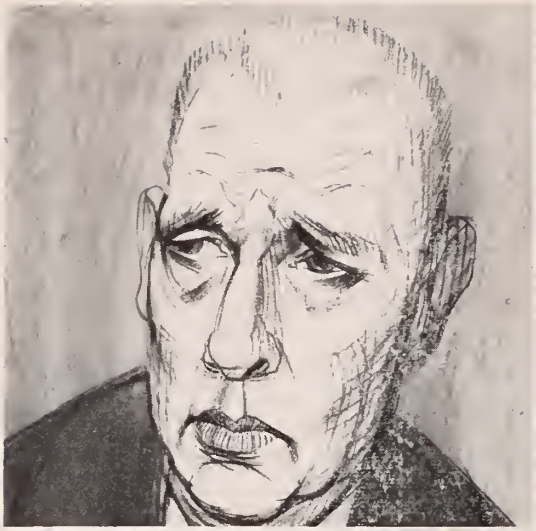
"There appears to be no doubt that kanamycin has been lifesaving in those instances in which organismal resistance precludes the use of other antimicrobials."[4]

Information on dosage, administration and precautions contained in package insert or available on request.

SUPPLY: KANTREX Injection, 0.5 Gm. kanamycin (as sulfate) in vial containing 2 ml. volume. KANTREX Injection, 1.0 Gm. kanamycin (as sulfate) in vial containing 3 ml. volume.

REFERENCES: 1. Yow, E. M.: Practitioner 182:759, 1959. 2. Yow, M. D., and Womack, G. K.: Ann. N. Y. Acad. Sci. 76:363, 1958. 3. Bunn, P. A., Baltch, A., and Krajnyak, O.: Ibid. 76:109, 1958. 4. Council on Drugs, J.A.M.A. 172:699, 1960.

BRISTOL LABORATORIES, SYRACUSE, NEW YORK



whenever depression complicates the picture

Tofrānil®
brand of imipramine HCl

hastens recovery

Geigy

In many seemingly mild physical disorders an element of depression plays an insidious etiologic or complicating role.

Because of its efficacy as an antidepressant, coupled with its simplicity of usage, Tofrānil is admirably adapted to use in the home or office in these milder "depression-complicated" cases.

It is always wise to recognize that depression may be an underlying factor...that Tofrānil may speed recovery in "hypochondriasis"; in convalescence when recovery is inexplicably prolonged; in chronic illness with dejection; in the menopausal patient whose emotional disturbances resist hormone therapy; and in many other comparable situations in which latent depression may play a part.

Detailed Literature Available on Request.

Tofrānil®, brand of imipramine hydrochloride, tablets of 25 mg. Ampuls for intramuscular administration, 25 mg. in 2 cc. of solution.

Geigy, Ardsley, New York

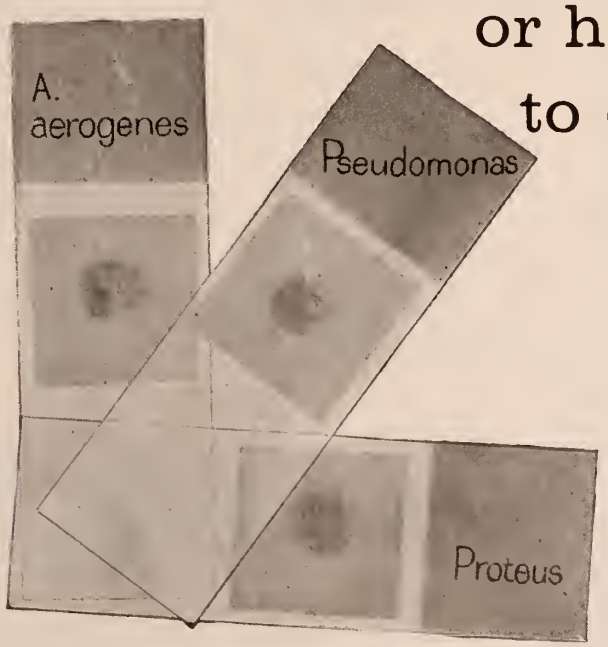
160-60

DECLOMYCIN® NOTES:

Demethylchlortetracycline Lederle

pathogen
sensitivity

In addition to the expected broad-spectrum range of effectiveness, DECLOMYCIN has demonstrated activity against strains of Pseudomonas, Proteus and A. aerogenes[1-4] unresponsive or highly refractory to other antibiotics.



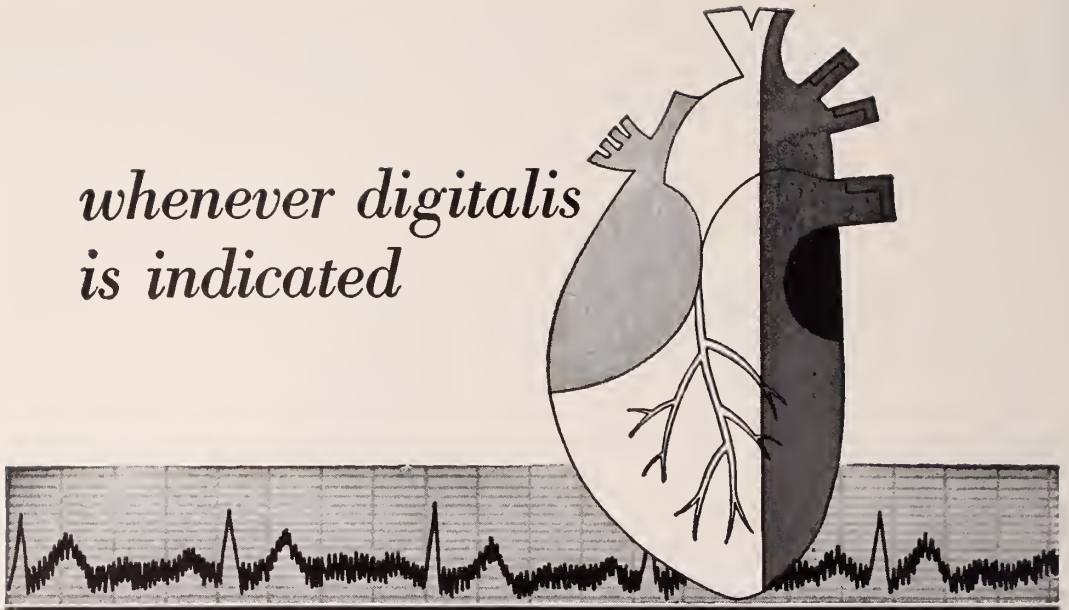
1. Finland, M.; Hirsch, H. A., and Kunin, C. M.: Read at Seventh Annual Antibiotics Symposium, Washington, D. C., November 5, 1959. 2. Hirsch, H. A.; Kunin, C. M., and Finland, M.: München. med. Wchnschr. To be published. 3. Roberts, M. S.; Seneca, H., and Lattimer, J. K.: Read at Seventh Annual Antibiotics Symposium, Washington, D. C., November 5, 1959. 4. Vineyard, J. P.; Hogan, J., and Sanford, J. P.: Ibid.

Capsules, 150 mg. — Pediatric Drops, 60 mg./cc. — New Syrup, cherry-flavored, 75 mg./5 cc. tsp., in 2 fl. oz. bottle — 3-6 mg. per lb. daily in four divided doses.

GREATER ACTIVITY... FAR LESS ANTIBIOTIC... SUSTAINED-PEAK CONTROL... "EXTRA-DAY" PROTECTION AGAINST RELAPSE

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

whenever digitalis is indicated



'LANOXIN'® brand DIGOXIN

formerly known as Digoxin 'B. W. & Co.'®

"If one digitalis agent were to be recommended for its adaptability to the many and varied clinical contingencies, we believe Digoxin would be the drug of choice."

Lown, B., and Levine, S. A.: Current Concepts in Digitalis Therapy, Boston, Little, Brown & Company, 1954, p. 23, par. 2.

'LANOXIN' TABLETS
0.25 mg. scored (white)
0.5 mg. scored (green)

'LANOXIN' INJECTION
0.5 mg. in 2 cc. (I.M. or I.V.)

'LANOXIN' ELIXIR PEDIATRIC
0.05 mg. in 1 cc.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

Of course, women like "Premarin"®

THERAPY for the menopause syndrome should relieve not only the psychic instability attendant the condition, but the vasomotor instability of estrogen decline as well. Though they would have a hard time explaining it in such medical terms, this is the reason women like "Premarin."

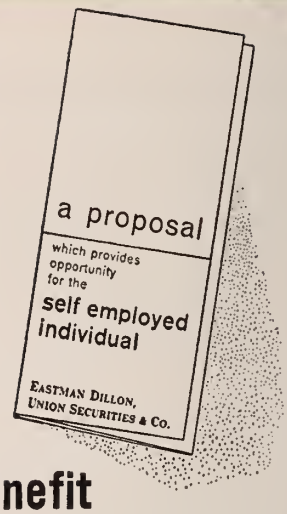
The patient isn't alone in her devotion to this natural estrogen. Doctors, husbands, and family all like what it does for the patient, the wife, and the homemaker.

When, because of the menopause, the psyche needs nursing—"Premarin" nurses. When hot flushes need suppressing, "Premarin" suppresses. In short, when you want to treat the whole menopause, (and how else is it to be treated?), let your choice be "Premarin," a complete natural estrogen complex.

"Premarin," conjugated estrogens (equine), is available as tablets and liquid, and also in combination with meprobamate or methyltestosterone.

Ayerst Laboratories • New York 16, N. Y. • Montreal, Canada

TAX SAVINGS FOR THE SELF-EMPLOYED INDIVIDUAL



New booklet explains how you may benefit

Pending Federal legislation, if passed, provides important advantages and tax savings through a voluntary retirement program.

Our new free booklet explains who would be eligible, and what course of action should *now* be taken. For your copy, fill in and mail the coupon below to our office nearest you.

NAME_____

ADDRESS_____

_____ TELEPHONE_____

NJ-7

I plan to retire in about_____years.

EASTMAN DILLON, UNION SECURITIES & CO.

MEMBERS NEW YORK STOCK EXCHANGE

Main Office: **15 Broad Street, New York 5**

Phila. Nat'l. Bank Bldg.
Philadelphia 7, Pa.
LOcust 8-5800

35 Church Street
Paterson 1, N. J.
ARmory 1-1000

Furadantin®

brand of nitrofurantoin

"... by far the most effective drug to be employed, and this has been substantiated in practice. It is a drug of low toxicity and, what is more important, bacteria rarely if ever become resistant to it. It can be employed for long periods of time, is bactericidal and does not favor the appearance of monilial infections."[3]

Indicated in: acute and chronic prostatitis ▪ benign prostatic hypertrophy (to prevent or treat concomitant infection) ▪ postoperatively in prostatic surgery

Supplied: Tablets, 50 and 100 mg., Oral Suspension, 25 mg. per 5 cc. tsp.

References: 1. Campbell, M. F.: Principles of Urology, Philadelphia, W. B. Saunders Co., 1957. 2. Farman, F., and McDonald, D. F.: Brit. J. Urol. **31**:176, 1959. 3. Sanjurjo, L. A.: Med. Clin. N. America **43**:1601, 1959.

EATON LABORATORIES, NORWICH, NEW YORK

strengthens
fragile capillaries

in internal bleeding

capillary hemorrhage
in duodenal ulcer

. . . associated with abnormal capillary permeability and fragility in

peptic ulcer

ulcerative colitis

chronic nosebleed

purpura
(nonthrombocytopenic)

hemorrhagic cystitis

ecchymoses

menorrhagia

habitual and threatened abortion

CVP®

C.V.P. helps diminish increased capillary permeability, fragility, and resultant bleeding by acting to maintain the integrity of the intercellular ground substance (cement) of capillary walls. C.V.P. is the original and exclusive water-soluble citrus bioflavonoid complex. Readily absorbed and utilized, C.V.P. is relatively free (due to special processing) of hesperidin, naringin and other comparatively insoluble and inactive flavonoids found in citrus.

Each capsule or teaspoonful (approx. 5 cc.) of syrup provides:

CITRUS BIOFLAVONOID COMPOUND	100 mg.
ASCORBIC ACID (vitamin C)	100 mg.

Bottles of 100, 500 and 1000 capsules; 4 oz., 16 oz. and gallon syrup

samples (capsules or syrup) and literature from . . .

u. s. vitamin corporation • PHARMACEUTICALS

(Arlington-Funk Laboratories, division) • 250 East 43rd Street, New York 17, N. Y.

Proven

in over five years of clinical use and more than 750 published clinical studies

Effective

for relief of anxiety and tension

Outstandingly Safe

- simple dosage schedule produces rapid, reliable tranquilization without unpredictable excitation
- no cumulative effects, thus no need for difficult dosage readjustments
- does not produce ataxia, change in appetite or libido
- does not produce depression, Parkinson-like symptoms, jaundice or agranulocytosis
- does not impair mental efficiency or normal behavior

for the tense and nervous patient

Despite the introduction in recent years of "new and different" tranquilizers, Miltown continues, quietly and steadfastly, to gain in acceptance. Generically and under the various brand names by which it is distributed, meprobamate (Miltown) is prescribed by the medical profession more than any other tranquilizer in the world.

The reasons are not hard to find. Miltown is a *known* drug, evaluated in more than 750 published clinical reports. Its few side effects have been fully reported; there are no surprises in store for either the patient or the physician. It can be relied upon to calm anxiety and tension quickly and predictably.

Usual dosage: One or two 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets; or as MEPROTABS*—400 mg. *unmarked,* coated tablets.

* TRADE-MARK

Miltown®

meprobamate (Wallace)

WALLACE LABORATORIES / *New Brunswick, N. J.*

CM-2053

when that early Monday morning telephone call is from a weekend do-it-yourselfer

"...and this morning, Doctor, my back is so stiff and sore I can hardly move."

now...there is a way to prompt, dependable relief of back distress

the pain goes while *the muscle relaxes*

POTENT — rapid relief in acute conditions

SAFE — for prolonged use in chronic conditions

notable safety — extremely low toxicity; no known contraindications; side effects are rare; drowsiness may occur, usually at higher dosages

rapid action, sustained effect — starts to act quickly, relief lasts up to 6 hours

easy to use — usual adult dosage is one 350 mg. tablet 3 times daily and at bedtime

supplied — as 350 mg., white, coated tablets, bottles of 50; *also available for pediatric use:* 250 mg., orange capsules, bottles of 50

WALLACE LABORATORIES, New Brunswick, New Jersey

SOMA T.M.

(CARISOPRODOL WALLACE)

For topical infections, choose a 'B. W. & Co.'® 'SPORIN'...

Combines the anti-inflammatory effect of hydrocortisone with the comprehensive bactericidal action of the antibiotics.

Each gram contains:
'Aerosporin'® brand Polymyxin B Sulfate 5,000 Units
Zinc Bacitracin ..... 400 Units
Neomycin Sulfate ..... 5 mg.
Hydrocortisone ..... (1%) 10 mg.
in a special petrolatum base.

Provides comprehensive bactericidal action effective against virtually all bacteria likely to be found topically.

Each gram contains:
'Aerosporin'® brand Polymyxin B Sulfate 5,000 Units
Neomycin Sulfate ..... 5 mg.
Zinc Bacitracin ..... 400 Units
in a special petrolatum base.

Offers combined antibiotic action for treating conditions due to susceptible organisms amenable to local medication.

Each gram contains:
'Aerosporin'® brand
Polymyxin B Sulfate ..... 10,000 Units
Zinc Bacitracin ..... 500 Units
in a special petrolatum base.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N. Y.

Beating too fast?

Slow it down with SERPASIL®

(reserpine CIBA)

Serpasil has proved effective as a heart-slowing agent in the following conditions: mitral disease; myocardial infarction; cardiac arrhythmias; neurocirculatory asthenia; thyroid toxicosis; excitement and effort syndromes; cardiac neurosis; congestive failure. Serpasil should be used with caution in patients receiving digitalis and quinidine. It is not indicated in cases of aortic insufficiency.

SUPPLIED: Tablets, 0.1 mg., 0.25 mg. (scored) and 1 mg. (scored). Complete information available on request.

CIBA

SUMMIT·NEW JERSEY

2/2819MB

A most appetizing help for patients where a cholesterol depressant diet is prescribed

Wesson's Chicken Cook Book
FREE in quantities
for your distribution to patients

The enticing variety of dishes offered in "*101 Glorious Ways to Cook Chicken*" can help make a restricted regimen less monotonous and encourages the patient's compliance with it.

The high poly-unsaturated fat content of poultry—prepared in poly-unsaturated Wesson—makes it a special help to those on cholesterol depressant diets. Happily, too, chicken is moderate in calories, universally popular and one of the most economical protein foods in the grocery today.

Recipes for Chicken Rosemary, Sesame, Jambalaya, Pilaf, etc., teach scores of new ways to enhance chicken with herbs and spices, new combinations with fruits and vegetables, how to use sauces and seasonings wisely and well. Careful consideration has been given to the choice of ingredients to keep saturated fats to a minimum.

Where a vegetable (salad) oil is medically recommended for a cholesterol depressant regimen, Wesson is unsurpassed by any readily available brand.

:HICKEN SESAME—with its crunchy nutlike flavor from the Indies—is typical of the glorious eating contained in this new Wesson cook book.

/ESSON'S IMPORTANT CONSTITUENTS

Wesson is 100% cottonseed oil . . .
winterized and of selected quality

.inoleic acid glycerides (poly-unsaturated)	50-55%
)leic acid glycerides (mono-unsaturated)	16-20%
Total unsaturated	70-75%
Palmitic, stearic and myristic glycerides (saturated)	25-30%
Phytosterol (predominantly beta sitosterol)	0.3-0.5%
Total tocopherols	0.09-0.12%

Never hydrogenated—completely salt free

Each pint of Wesson contains 437-524 Int. Units of Vitamin E

Send coupon for quantity needed for your patients.

The Wesson People, 210 Baronne Street, New Orleans 12, La.

Please send me . . . free copies of the Wesson cook book "101 Glorious Ways to Cook Chicken."

Name.....

Address.....

City.....Zone.....State.....

Lifts depression..

You see an improvement within a few days
Thanks to your prompt treatment and the smooth action of Deprol, her depression is relieved and her anxiety and tension calmed – *often in a few days.* She eats well, sleeps well and soon returns to her normal activities.

as it calms anxiety!

Smooth, balanced action lifts depression as it calms anxiety... rapidly and safely

Balances the mood — no "seesaw" effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient —*they often aggravate anxiety and tension.*

And although amphetamine-barbiturate combinations may counteract excessive stimulation—*they often deepen depression.*

In contrast to such "seesaw" effects, Deprol's smooth, *balanced* action lifts depression as it calms anxiety—both at the same time.

Acts swiftly — the patient often feels better, sleeps better, within a few days. Unlike the delayed action of most other antidepressant drugs, which may take two to six weeks to bring results, Deprol relieves the patient quickly — often within a few days. Thus, the expense to the patient of long-term drug therapy can be avoided.

Acts safely — no danger of liver damage. Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function—frequently reported with other antidepressant drugs.

Bibliography *(13 clinical studies, 858 patients)*: **1.** Alexander, L. (35 patients): Chematherapy of depression — Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. **2.** Bateman, J. C. and Carlton, H. N. (50 patients): Meprobamate and benactyzine hydrochloride (Deprol) as adjunctive therapy for patients with advanced cancer. Antibiotic Med. & Clin. Therapy 6:648, Nov. 1959. **3.** Beerman, H. M. (44 patients): The treatment of depression with meprobamate and benactyzine hydrochloride. Western Med. 1:10, March 1960. **4.** Bell, J. L., Tauber, H., Santy, A. and Pulito, F. (77 patients): Treatment of depressive states in office practice. Dis. Nerv. System 20:263, June 1959. **5.** Breitner, C. (31 patients): On mental depressions. Dis. Nerv. System 20:142, (Section Two), May 1959. **6.** Gordon, P. E. (50 patients): Deprol in the treatment of depression. Dis. Nerv. System 21:215, April 1960. **7.** Landman, M. E. (50 patients): Clinical trial of a new antidepressive agent. J. M. Soc. New Jersey. In press, 1960. **8.** McClure, C. W., Papas, P. N., Speare, G. S., Palmer, E., Slattery, J. J., Kanefal, S. H., Henken, B. S., Wood, C. A. and Ceresia, G. B. (128 patients): Treatment of depression — New technics and therapy. Am. Pract. & Digest Treat. 10:1525, Sept. 1959. **9.** Pennington, V. M. (135 patients): Meprobamate-benactyzine (Deprol) in the treatment of chronic brain syndrome, schizophrenia and senility. J. Am. Geriatrics Soc. 7:656, Aug. 1959. **10.** Rickels, K. and Ewing, J. H. (35 patients): Deprol in depressive conditions. Dis. Nerv. System 20:364, (Section One), Aug. 1959. **11.** Ruchwarger, A. (87 patients): Use of Deprol (meprobamate combined with benactyzine hydrochloride) in the office treatment of depression. M. Ann. District of Columbia 28:438, Aug. 1959. **12.** Settel, E. (52 patients): Treatment of depression in the elderly with a meprobamate-benactyzine hydrochloride combination. Antibiotic Med. & Clin. Therapy 7:28, Jan. 1960. **13.** Splitter, S. R. (84 patients): Treatment of the anxious patient in general practice. J. Clin. & Exper. Psychopath. In press, April-June 1960.

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate.
Supplied: Bottles of 50 light-pink, scored tablets. Write for literature and samples.

Deprol®

WALLACE LABORATORIES / *New Brunswick, N. J.*

CO-2128

NOW ORDER FINEST MARINE EQUIPMENT AT LOW FACTORY-TO-YOU PRICES!

SHIP-TO-SHORE

30-WATT TRANSISTOR RADIO-TELEPHONE

Includes everything: Hartman's Model 3059 has Antenna, Microphone, Mounting Brackets, all Crystals.

$219.95

- PRE-TUNED AT FACTORY
- FCC APPROVED
- Battery drain less than 1/5 amp.
- Transmits up to 125 miles
- Portable—weighs just 10 pounds
- Simple to install
- Needs no warmup

5 separate channels — call anywhere!

- Marine Telephone Channel
- Broadcast Channel
- Two Ship-to-Ship Channels
- Coast Guard Emergency Channel

REMOTE STATION

Doubles the versatility of your Hartman Ship-to-Shore Radio-Telephone . . . like having two radio-telephones instead of one!

$29.95

ALL-TRANSISTOR SEA SOUNDER

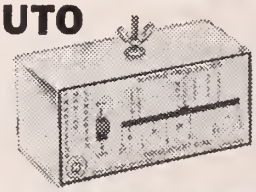
- lets you know depth of water
- locates best fishing grounds
- makes for safer boating in all waters
- ideal as a navigational aid

$99.50

Never drains from your battery because it uses own self-contained flashlight cells. Optional: Can be operated from your 12 Volt Boat Battery if desired.

ALL-TRANSISTOR SHIP-TO-AUTO

RADIO FREQUENCY CONVERTER



Listen to marine broadcasts on your own car radio! Just a flick of the switch makes your radio into a powerful, long-range marine receiver.

$19.59

- Fits any car radio
- Install it in seconds

FILL IN THIS COUPON NOW AND MAIL IT TODAY!

HARTMAN MARINE EQUIPMENT CORPORATION

30-30 Northern Boulevard, Long Island City 1, N. Y.

Enclosed is Check or Money Order for:
☐ Radio-Telephone ☐ Sea Sounder ☐ Auto-Marine Converter
Please send following C.O.D.:
☐ Radio-Telephone ☐ Sea Sounder ☐ Auto-Marine Converter
☐ Please send more information on sets checked above.

Name _____

Address _____

City _____ Zone _____ State _____

whenever there is inflammation, swelling, pain

VARIDASE BUCCAL *Tablets*

STREPTOKINASE-STREPTODORNASE LEDERLE

conditions for a fast comeback... as in acute hemorrhoids...

SUNDAY, 9 A.M.: VARIDASE for painful thrombotic hemorrhoid. 2:30 P.M.: pain greatly reduced, less swelling and inflammation.

MONDAY: size down to small tab; acute inflammation disappeared.*

VARIDASE activates natural fibrinolytic factors, to limit undesirable inflammatory response and speed healing.

Dramatic reduction of pain is often the first sign of improvement: swelling and redness rapidly diminish. Drugs and natural regenerative factors readily penetrate the inflammatory barrier to effect total remission faster... in trauma or infection.

VARIDASE Buccal Tablets contain:
10,000 Units Streptokinase, 2,500 Units Streptodornase.
Supplied: Boxes of 24 and 100 tablets

*Peterman, R. A.: Clinical report cited with permission.

Lederle

LEDERLE LABORATORIES,
a Division of American Cyanamid Company, Pearl River, N. Y.

massages pain away in musculoskeletal involvements[1]

GER-O-FOAM

(aerosol foam)

relieves pain, spasm; improves function increases tolerance to exercise

GER-O-FOAM's exclusive formula provides for the first time deeply absorbed analgesic-anesthetic agents in aerosol form — to permeate and anesthetize sensory nerve endings.

Relief in minutes, lasting for hours in . . . rheumatoid arthritis, osteoarthritis, muscle sprain, fibromyositis, low back pain . . . even in chronic intractable cases.

GER-O-FOAM combines: Methyl salicylate 30%, benzocaine 3%, in a neutralized emulsion base, permitting fast penetration through the stratum corneum.

Sample and reprint from

GERIATRIC PHARMACEUTICAL CORP.
Bellerose, New York

Pioneers In Geriatric Research

1. Gordon, E. E. and Haas, A.: Industrial Medicine & Surgery 28:217, 1959.

GERIATRIC

. . . MALNUTRITION OR LEG CRAMPS DURING PREGNANCY?

OUTMODED AS GODEY'S FASHIONS!

Rx NEW

PRENALIN-O®

PRENATAL SUPPLEMENT

1. Oyster Shell Calcium - Phosphorus Free!
2. New Form of Iron!
3. Dry Filled Capsule - Sure, Quick Absorption!
4. Economical Once-A-Day Dosage!
5. Wider Range Nutritional Support!
6. Relieves Troublesome Leg Cramps!

EACH dry filled capsule (lavender and white) provides:

Ferrous Fumarate (Iron)	150 mg.	Vitamin B-12 (Cobalamin conc NF)	2 mcg
Deep sea oyster shell (Calcium)	600 mg.	Folic Acid	0.25 mg
Vitamin C	50 mg.	Niacinamide	10 mg.
Vitamin A	4000 USP Units	Vitamin K (Menadione)	0.25 mg.
Vitamin D	400 USP Units	Rutin	10 mg.
Vitamin B-1	2 mg.	Sodium Molybdate	3 mg
Vitamin B-2	2 mg.	Fluorine (Calcium Fluoride)	0.25 mg.
Vitamin B-6	0.8 mg.	Iodine (Potassium Iodide)	0.15 mg

SAMPLES ON REQUEST

TUTAG

S. J. TUTAG & CO.
DETROIT 34, MICHIGAN

51 to 49...it's a boy!

94 to 6 BONADOXIN® stops morning sickness

When she asks "Doctor, what will it be?" you can either flip a coin or point out that 51.25% births are male.[1] But when she mentions morning sickness, your course is clear: BONADOXIN.

For, in a series of 766 cases of morning sickness, seven investigators report excellent to good results in 94%.[2] More than 60 million of these tiny tablets have been taken. The formula: 25 mg. Meclizine HCl (for antinauseant action) and 50 mg. Pyridoxine HCl (for metabolic replacement). Just one tablet the night before is usually enough.

BONADOXIN—DROPS and Tablets—are also effective in infant colic, motion sickness, labyrinthitis, Meniere's syndrome and for relieving the nausea and vomiting associated with anesthesia and radiation sickness. See PDR p. 795.

1. Projection from Vital Statistics, U.S. Government Dept. HEW, Vol. 48, No. 14, 1958, p. 398.
2. Modell, W.: Drugs of Choice 1958-1959, St. Louis, C. V. Mosby Company, 1958, p. 347.

Roerig
New York 17, New York
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being

THE JOHNSTON MUTUAL FUND Inc.

AN INVESTMENT IN A CROSS SECTION OF AMERICAN BUSINESS AND INDUSTRY

SHARES MAY BE PURCHASED, OR REDEEMED, AT NET ASSET VALUE

There is no Sales Load or Commission and no Redemption Charge.

ACCUMULATION PLAN AVAILABLE

Also Group Investment Plan for groups of 20 or more.

Mail Coupon for Free Prospectus

THE JOHNSTON MUTUAL FUND Inc.
230 PARK AVENUE - DEPARTMENT J
New York 17, New York
ORegon 9-2700

NAME .....

ADDRESS .....

.....

CLINICAL REMISSION IN A "PROBLEM" ARTHRITIC

In "escaping" rheumatoid arthritis. After gradually "escaping" the therapeutic effects of other steroids, a 52-year-old accountant with arthritis for five years was started on DECADRON, 1 mg./day. Ten months later, still on the same dosage of DECADRON, weight remains constant, she has lost no time from work, and has had no untoward effects. She is in clinical remission.*

New convenient b.i.d. alternate dosage schedule: the degree and extent of relief provided by DECADRON allows for b.i.d. maintenance dosage in many patients with so-called "chronic" conditions. Acute manifestations should first be brought under control with a t.i.d. or q.i.d. schedule.

Supplied: As 0.75 mg. and 0.5 mg. scored, pentagon-shaped tablets in bottles of 100. Also available as Injection DECADRON Phosphate. Additional information on DECADRON is available to physicians on request. DECADRON is a trademark of Merck & Co., Inc.

*From a clinical investigator's report to Merck Sharp & Dohme.

Decadron®

Dexamethasone

TREATS MORE PATIENTS MORE EFFECTIVELY

MSD MERCK SHARP & DOHME • Division of Merck & Co., INC., West Point, Pa.

The physician listens to a tense, nervous patient to discuss her emotional problems. To help her, he prescribes Meprospan (400 mg.), the only continuous-release form of meprobamate.

The patient takes one Meprospan-400 capsule at breakfast. She has been suffering from recurring states of anxiety which have no organic etiology.

She stays calm while on Meprospan, even under the pressure of busy, crowded supermarket shopping. And she is not likely to experience any autonomic side reactions, sleepiness or other discomfort.

She takes another capsule of Meprospan-400 with her evening meal. She has enjoyed sustained tranquilization all day—and has had no between-dose letdowns. Now she can enjoy sustained tranquilization all through the night.

Relaxed, alert, attentive . . . she is able to listen carefully to P.T.A. proposals. For Meprospan does not affect either her mental or her physical efficiency.

Peacefully asleep . . . she rests, undisturbed by nervousness or tension. (Literature on Meprospan is available from Wallace Laboratories, Cranbury, N. J.)

Schering

fulvicin™

GRISEOFULVIN

clears ringworm orally regardless of duration or previous resistance to treatment

spares the patient—embarrassment of epilation and skullcaps, difficulty and ineffectiveness of topical medications, potential hazard of x-ray treatments

6-425

Co-Pyronil®

keeps most allergic patients symptom-free around the clock

Many allergic patients require only *one* Pulvule® Co-Pyronil every *twelve** hours, because Co-Pyronil provides:

- Prolonged antihistaminic action
- Fast antihistaminic action

  plus
- Safe, effective sympathomimetic therapy

*Unusually severe allergic conditions may require more frequent administration. Co-Pyronil rarely causes sedation and, even in high dosage, has a very low incidence of side-effects.

Supplied as Pulvules, Suspension, and Pediatric Pulvules.

Co-Pyronil® (pyrrobutamine compound, Lilly)

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U.S.A.

058012

THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

Shipment of Laboratory Animals

If the anti-vivisectionists have their way (or if scientists fall asleep at the switch), Congress will adopt a bill to obstruct interstate shipment of laboratory animals. Most people do not know how much their lives depend on monkeys from India, mice from Maine, dogs from Louisiana. There are already many laws, federal and state, and many regulations both postal and interstate commerce, which regulate the shipment of these animals. There are rules touching on the size and sanitation of containers, feeding of animals en route, ventilation, watering of animals and so on. All kinds of animals are shipped, and whether protozoa or gorillas they are all needed. From amebae to worms they run the alphabetical gamut.

We need them to test the safety of drugs, the ways in which nerve impulses are transmitted, and the effect of variations in diet. We need them to study the basic chemical substratum of life and we need them to help track down hormones. Without these laboratory animals there can be no development in the science of immunology—no new sera or vaccines. We need them as testing grounds for newer surgical procedures.

Laboratory animals must be made swiftly available to any research facility anywhere in the country. State lines cannot be permitted to be stop-streets to medical progress. Those who would put up such hurdles may cry that they are but the friends of dumb animals. Maybe—but they are no friends to mankind, no friends to sick children. A child does not choke to death with diphtheria because—by use of laboratory animals—we have learned to make the antitoxin. Obstructive legislation would have prevented this—prevented the development of Salk vaccine. Let us hope that no such legislation will slip through by default.

PUBLISHED MONTHLY SINCE 1904
Under the direction of the Committee on Publication
FRED B. ROGERS, M.D., *Chairman*

HENRY A. DAVIDSON, M.D., *Editor*
MIRIAM N. ARMSTRONG, *Assistant Editor*

Place of Publication, Printing and Mailing—116 Lincoln Avenue, Orange, N. J.
Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.
Send all communications for publication to P.O. Box 904, Trenton 5, N. J. — Telephone EXport 4-3154
Each paying member of the State Society is entitled to receive a copy of THE JOURNAL every month
Whole Number of Issues 671

VOL. 57, NO. 7 JULY, 1960 Subscriptions, $3.00 per Year
Single Copies, 30 Cents

Delegates' Action on Blue-Cross, Blue-Shield Rider

The House of Delegates met on Sunday, March 13, 1960, in Trenton. Purpose of the meeting was to review and discuss the current status of existing and proposed riders for diagnostic services under Blue Cross and Blue Shield contracts, and to obtain direction from the House of Delegates as to the position of The Medical Society of New Jersey concerning such riders.

Of the 425 accredited members of the House (1959 list), 314 representatives attended the meeting—74 per cent.

ACTIONS

1. Dr. Allman moved—seconded by Dr. Kaufman, and *defeated* by a majority vote—that the House of Delegates approve a joint rider to be issued by Blue Cross and Blue Shield.

2. Dr. Donnelly moved—seconded by a number of delegates, and unanimously *carried*—that the President appoint a committee to meet with the Commissioner of the State Department of Banking and Insurance to state our reasons against the contemplated Blue Cross rider which would permit diagnostic services on an out-patient basis in hospitals.

Amendment to Dr. Donnelly's motion—made by Dr. Robie, seconded, and carried: This committee should be appointed to study this question in the interim between the next meeting that's coming soon, and they should be empowered to sit down with Blue Shield, with Blue Cross. We don't want to tie their hands just to go and see the Banking Commissioner. That committee should do work in various spheres, those that they think are necessary to help iron this thing out.

Trustees' Meeting: April 24, 1960

A regular meeting of our Board of Trustees was held April 24 in Trenton. Among actions taken were the following:

—On recommendation of the Council on Public Health, accepted an invitation from the New Jersey Tuberculosis and Health Association to join with the State Health Department in co-sponsoring a conference on standards for chemotherapy and on the availability of tuberculosis treatment facilities.

—Received and noted a report from Dr. Anthony Ambrose, Medical Society representative to the Pharmacopeia Convention, who suggested that all physicians own a copy of the *U. S. Pharmacopeia XVI* and refer to it frequently, along with the *National Formulary* and the NNR Pediatric dosage, which is being considered for inclusion in the next issue of USP.

The Trustees agreed to support the State Hospital Association in opposing A-555.

A-555 would modify procedures for providing trustees for Hospital Service Plan, empowering the Governor to appoint six "public trustees" and stipulating qualifications of other members.

A-556 would empower the Commissioner of Banking and Insurance to determine Medical-Surgical Plan rates of payment to participating physicians, and provide for appeal therefrom to the Superior Court under proper writ.

Mr. Nevin reported a communication from the Nurses' Association supporting the Society's opposition to A-556. The New Jersey Hospital Association had gone on record as opposing A-555. They asked that our Medical Society oppose the bill also.

Dr. Schretzmann moved—seconded by Dr. Kaufman, and carried—that the Medical Society support the opposition of the New Jersey Hospital Association on A-555, if a written request for such is received.

G. P. AWARD

The Mercer County Medical Society nominated a candidate for the AMA 1960 "General Practitioner of the Year" award. The Executive Officer was informed by AMA that:

> County societies nominate candidates to the state society; the state society considers all nominations submitted to it and selects *one* for referral to the American Medical Association. This candidate, together with those from other state societies is considered by a special "secret" committee appointed by the Chairman of the Board of Trustees. This committee, at a meeting prior to the Clinical Session reviews the qualifications of all candidates and nominates one individual to the Board of Trustees.

Dr. Greifinger moved—seconded by Dr. Kaufman, and carried—that a communication be sent to each component society inquiring if any have candidates for the award, indicating the Society can support only one candidate.

BLUE CROSS STUDY COMMITTEE REPORT

Mr. Nevin directed the Board's attention to the newspaper articles on the report of the New Jersey Blue Cross Rate Study Committee. These accounts blame the high cost of hospital care on the physician as he is responsible for admitting the patient to the hospital and for ordering procedures and treatment. The full report was not at the time available to the Medical Society.

After discussion of the contents of the newspaper articles and suggested counter-publicity, Dr. Schretzmann moved—seconded by Dr. Kaufman, and carried—that the following be approved:

1. That the President issue a general release.
2. That the secretary of each component society be acquainted with the chief points of the report derogatory to medicine, be supplied with a copy of the President's release, and be provided with further suggestions as to how to respond.
3. That it be suggested to each component society that at least two local physicians write letters to their local papers supplementing the general release issued by the President.

LEGISLATION

The following recommendations were received from our Council on Legislation. The Trustees took the action indicated.

S-147 (Ridolfi). This would permit school medical inspectors to accept the report of a physical examination made on a pupil by his treating physician in lieu of the examination required to be made by the school medical examiner or school nurse.

> *Recommendation*: Re-submit the entire matter to the House of Delegates for directive, in view of the lack of solidarity of support by members of The Medical Society of New Jersey, as reported by Senator Ridolfi.

The Trustees approved this recommendation.

Essex County Resolution—To favor active support for legislation "to provide ability and permission for a physician to bring countersuit against an individual suing the physician for malpractice or professional liability."

> *Recommendation*: No need for further legislation proposed by this resolution, in view of the opinions of the Legislative Analyst and of Legal Counsel to The Medical Society of New Jersey. The law, as it presently exists, affords equal protection to members of any and all professions, and extends as much advantage to the physicians as to the lawyers.

The Trustees approved this recommendation.

Authority to apply contact lenses. Our Committee on Conservation of Vision had asked us to state officially that the application of a contact lens to the human eye was, by its substance, part of the practice of medicine.

> The Council recommended that this be referred to our Legal Counsel for opinion. Our Legislative Analyst believes that the fitting of contact lenses by optometrists may be within the purview of the practice of optometry as legally defined. Our Legal Counsel has reported that this is now before the Attorney General of New Jersey and advised that we await developments. On motion, the Trustees referred this back to the Legislative Council with the comments of our Legal Counsel.

It is also proposed that we oppose any amendment to the Medical Practice Act, or any other legislative proposal, to extend to persons not licensed to practice medicine, any authority to engage in the application of any instrument or contact lenses, or any other object to the human eye.

> *Recommendation*: The Council accepts this recommendation and will oppose—as it has opposed—any amendment to the Medical Practice Act which will be detrimental to the practice of medicine and the public welfare.

The Trustees approved this recommendation.

The Council considered the following bills, and recommends the actions indicated in italics.

S-188 Ridolfi—To provide hospital, medical, and surgical expense insurance for state employees. *Approval*

S-189 Ridolfi—Companion bill to S-188. To provide major medical expense insurance for state employees. *Approval*

S-190 Ridolfi—Companion bill to S-188. To authorize the State House Commission to contract with insurance carriers for state employees' hospital, medical, and surgical expense insurance of a specified type. *Approval.*

A-621 Panaro, Farrington, Sweeney—Same as S-188 above. *Approval*

A-622 Panaro, Farrington, Sweeney—Same as S-189 above. *Approval*

A-623 Panaro, Farrington, Sweeney—Same as S-190 above. *Approval*

According to the Legislative Analyst, all the above bills overcome the objections of the Medical Society to prior bills of this nature, in that they would oblige the state to provide these services through private corporations.

S-195 Stout—To amend the Nursing Act of 1957 to permit a waiver of examination if application therefor is made "within six months of the effective date of this amendatory act" (practical nursing).

Dr. Kaufman directed the Board's attention to a communication from the New Jersey Nurses' Association requesting us to oppose S-195, which they believe to be unsound legislation.

Upon motion by Dr. Donnelly—seconded by Dr. Kaufman, and carried—the Society's position on Senate Bill 195 was indicated as "disapproved."

A-383 Hauser, Musto, Brown—To allow any legally incorporated humane society to enforce certain provisions of the laws relating to cruelty to animals. *Disapproval* . . . because existing laws which delegate this power to the SPCA are adequate.

A-555 D'Aloia, McGowan, Wilson—To establish procedures for trustees, including six public trustees, for hospital service corporations having more than 1,000,000 persons eligible for service.

No Action . . . unless or until the New Jersey Hospital Association takes a positive stand and requests support of its position by the Medical Society.

A-556 D'Aloia, McGowan, Wilson—To establish the procedure for the Banking and Insurance Commissioner to disapprove rates of medical service corporations and for court review thereof.

The Council recorded itself as in complete agreement with the statement made by the President, and sent to all members of the Medical Society, in opposition to A-556.

A-586 D'Aloia, Laufer—To provide that no person, other than a pharmacist, shall sell any preparation, mixture or compound of drugs containing codeine or any barbiturate to any person under the age of 21, and that no pharmacist shall sell such preparation or compound to such person except upon a written prescription of a physician, dentist, or veterinarian.

Approved with the recommendation that the bill be amended to include medications containing codeine-like derivatives.

A-611 D'Aloia—To amend the act regulating hospital service corporations to allow such corporations to issue a master group contract to employers and other policy holders; gives the Commissioners of Banking and Insurance authority to disapprove practices, rules, and procedures of a hospital service corporation where he feels that they are unjust or inequitable; provides for an annual general supervisory fee to be paid by such corporations.

The Council recommended no action unless or until the New Jersey Hospital Association takes a positive stand and requests support of its position by the Medical Society.

A-612 D'Aloia—Companion bill to A-611; concerns medical service corporations. *No action* . . . unless or until Medical-Surgical Plan takes a positive stand and requests support of its position by the Medical Society.

The Council was of the opinion that the inherent dangers in both A-611 and A-612 are basic —as called to its attention in the report of the Legislative Analyst. It recommended that these two bills be brought to the attention of Hospital Service Plan and Medical-Surgical Plan, with the recommendation that if these Plans adopt positions of active opposition to the measures, the Medical Society join them.

The Council also empowered the Executive Officer to share with Medical-Surgical Plan a copy of the Legislative Analyst's report concerning A-612, in the hope that it will be moved to take definite action in which The Medical Society of New Jersey can join.

Upon motion by Dr. Greifinger—seconded by Dr. Donnelly, and carried—the report on A-611 and A-612 was approved.

A-627 Franklin, Maraziti—To permit the appointment of chief medical examiners in 3rd class counties. *Approval*

Approved by the Trustees on recommendation of the Council.

MEDICARE PROGRAM

A supplemental agreement, administrative in nature, will change the date for Congressional appropriation from when the fiscal agent has been paying the doctor to the date when the medical service rendered to the patient is complete.

Dr. McCall moved—seconded by Dr. Donnelly, and carried—that the proper officers be authorized to execute the supplemental agreement.

STUDENT ATHLETIC SYMPOSIUM

The chairman of the Special Committee on Child Health, Dr. Robert E. Jennings, submitted a report on the April 2, 1960, symposium in East Orange.

As a result of the small number in the audience, and in view of the efforts expended, Dr. Jennings suggested that a similar symposium be presented at the time of the Annual meeting of the Society, possibly in conjunction with one of the sections. Interested members of allied groups could be invited to such a meeting.

Upon motion by Dr. Schretzmann—seconded by Dr. Jehl, and carried—the suggestion was referred to the Committee on Annual Meeting.

HONORARY MEMBERSHIP NOMINATION

Received from the Essex County Medical Society was a resolution presenting the name of Elmer L. Shaffer, Ph.D., for consideration as a candidate for election to Honorary Membership. This resolution was referred to the Committee on Honorary Membership.

ANNUAL REGISTRATION

Following discussion of the unfavorable aspects of annual registration, Dr. Donnelly moved—seconded by Dr. Greifinger, and carried—that the Board's action of March 20, 1960, be rescinded (". . . that the Board approve the reintroduction of annual registration legislation and that the matter be brought before the 1960 House of Delegates for action").

ACCREDITATION OF MEDICAL SCHOOLS

The Trustees received a reply to the Board's inquiry to the Council on Medical Education and Hospitals as to why AMA gave up its activity of approving medical schools; and question as to what protection State Boards of Medical Examiners now have in approving medical schools without the assistance of a national approving agency, which stated:

> This Council has continuously maintained its accrediting function of medical schools since the early part of this century. Each year in the annual Education Number of *The Journal* of this Association, we publish an up-to-date approved list of medical schools in the United States and Canada. (JAMA, Vol. 171, November 14, 1959)

DIAGNOSTIC CYSTOSCOPIES

A resolution adopted by HSP Board of Trustees on December 17, 1959 reads:

> *Resolved*, that the Plan continue to pay claims where cystoscopic procedures are related to *treatment* only, and decline claims for cystoscopic procedures which are unrelated to treatment and
>
> *Further Resolved*, that Plan payment for cystoscopic procedures as a diagnostic service be considered for inclusion in any subsequent new Subscription Contract which the Plan may offer subsequent to the Series 1960 Comprehensive and Modified Comprehensive Subscription Contracts effective January 1, 1960.

HSP stated that inasmuch as the referred cystoscopic procedures unrelated to actual treatment were not included in the Plan's present rate structure, further consideration probably will have to be included in consideration of any new Subscription Contract, the timing of which is presently uncertain.

CENTER FOR SENIOR CITIZENS

At its meeting on December 20, 1959, the Board approved in principle (with no commitment regarding the details subsequently to be presented) a pilot study to consolidate deliberations and collect data on day care for the aged with the view of making a practical proposal of a "day nursery" type installation.

Received from the Committee on Aging of the New Jersey Neuropsychiatric Association was an outline of the pilot study with the request that it be approved by the Board of Trustees for transmittal to the Director of the

State Division of Aging. The covering letter stated in part:

> There was no specific start made to plan a facility not requiring direct medical supervision nor requiring supervision by the Department of Institutions and Agencies, in line with specific requests made by Mrs. Harper last fall. We hope to make a start which may lead to the establishment of Day and Night Hospitals, which at present, is unacceptable to the Department of Aging.

Upon motion by Dr. Kaufman—seconded by Dr. Jehl, and carried—the proposed pilot plan was approved.

FORAND BILL

Received and noted was a letter from the Administrative Assistant to the Vice President in reply to the letter from President Bowers commenting on the Forand Bill. This had been sent pursuant to Board directive dated March 20, 1960.

The letter stated in part that the Vice President has consistently opposed and will continue to oppose any compulsory health insurance program. He is aware of the great progress that has been made in meeting the problem of providing adequate health care through the cooperative endeavors of private practitioners and private voluntary group health insurance programs. He believes that the best way to handle the problem of people over 65 who do not have and cannot afford health insurance is through a program which will enable those who desire to do so to purchase health insurance covering catastrophic illnesses from private group carriers on a voluntary basis.

DISTRIBUTION OF MINUTES

A letter from the Ocean County Medical Society voiced strong objection to the Board's action directing that Board minutes not be distributed to county secretaries prior to the minutes receiving final approval. The letter requested that the former method of distribution be continued at least insofar as county society distribution is concerned.

Dr. Mulligan stated that the Board had taken a justifiable position in deciding *not* to distribute the minutes before the Board had an opportunity to discuss them at the following meeting. Frequently the minutes are changed, and only the final approved minutes should be distributed to anyone outside the Board.

With the consent of the Board, the Chairman directed that the Ocean County Medical Society be notified of the reasons for the Board's action, and that the distribution of the minutes be continued in accordance with this action.

Examination of School Children by Family M.D.

The following communication was sent by the Bergen County Medical Society to all New Jersey Assemblymen.

The Bergen County School and Child Health Committee would appeal to all counties concerning Senate Bill 147 (1959) originating in this county, originally approved by the State Medical Society in 1958, and introduced in the Legislature by Senator Ridolfi. This would permit the school physician to accept the physical examination performed by the family physician in lieu of doing it himself.

The House of Delegates at the 1960 Annual Meeting of The Medical Society of New Jersey unanimously voted the re-introduction of this to the New Jersey Legislature.

A misunderstanding has prevented the passage of this Bill. We are *not* asking all schools to adopt this system. They may continue to do as they wish. We only seek the *right* to continue practicing without any possible legal question the modern concept of school medicine, which has been successfully backed by the American Medical Association, and has been put in practice by progressive states for some time. This concept and philosophy encourages the analytic, administrative and educational role of the school physician in the school setting, and was presented and discussed at some length in an article by Dr. Levitas and Dr. Hudson in The Journal of The Medical Society of New Jersey (Vol. 56, Aug. 1959).

194th Annual Meeting — May 14-18, 1960
Haddon Hall, Atlantic City

Scientific Exhibit Awards

Class I—Scientific exhibits of individual investigation, judged on the basis of originality and excellence of presentation:

First Place: Open Heart Surgery at the Passaic General Hospital

Theodore K. Keith, M.D., Dryden P. Morse, M.D., Michael Ramundo, M.D., Daniel Downing, M.D., F. Albert Graeter, M.D., William Cantwell, M.D., Nathan Nussbaum, M.D., and Lawrence E. Batlan, M.D., Passaic General Hospital, Passaic

Second Place: Progress in the Management of Essential Hypertension

Garfield G. Duncan, M.D., Robert J. Gill, M.D., William J. Jenson, M.D., Brooks W. Gilmore, M.D., and Richard B. Freeman, M.D., The Pennsylvania Hospital, Philadelphia, Pa.

Honorable Mention: The Comparative Clinical Pharmacology and Effectiveness of the Newer Corticoids

Herbert S. Kupperman, M.D., and Jeanne A. Epstein, M.D., New York University-Bellevue Medical Center, Department of Therapeutics, New York, N.Y.

Class II—New Jersey Exhibitors:

First Place: Neonatal Surgical Emergencies

Richard C. Reed, M.D., and Celestino Clemente, M.D., The United Hospitals of Newark—Babies Hospital Unit, Newark

Second Place: Diseases of the Digestive Tract in Natural Color

Martin R. Rush, M.D., Aldo G. Baldi, M.D., Eugene Tchekunow, M.D., Joseph DeLorenzo, M.D., and Walter Richmond, Monmouth Medical Center, Long Branch

Honorable Mention: Maxillo Facial Rehabilitation

Michael L. Lewin, M.D., and Eugene Gottlieb, M.D., Paterson

Official Attendance

County	Delegates	Members	Total
Atlantic	11	76	87
Bergen	41	39	80
Burlington	6	15	21
Camden	22	49	71
Cape May	2	8	10
Cumberland	6	14	20
Essex	76	167	243
Gloucester	5	15	20
Hudson	33	40	73
Hunterdon	3	3	6
Mercer	26	54	80
Middlesex	17	46	63
Monmouth	21	46	67
Morris	16	23	39
Ocean	5	7	12
Passaic	33	44	77
Salem	3	9	12
Somerset	7	10	17
Sussex	3	3	6
Union	37	45	82
Warren	3	4	7
Fellows, Officers, Trustees, Councilors	19	0	19
	395	717	1,112

Physician Guests	105
Physician Exhibitors	37
TOTAL PHYSICIAN REGISTRATION	1,254
Auxiliary Members	479
Visitors	484
Exhibitors	344
TOTAL REGISTRATION	2,561

FIVE-YEAR COMPARATIVE REGISTRATION FIGURES

Year	Physicians	Others	Totals
1960(*)	1,254	1,307	2,561
1959	1,124	932	2,056
1958	1,193	950	2,143
1957	1,202	909	2,111
1956	1,238	947	2,185

*(highest registration on record—physicians and total)

Supplementary List No. 5

to the

1959-60 Membership Directory

Memberships reported from May 11, 1960 through June 10, 1960

R—Reinstated
N—New

	Name	Address	County	Practice
		ACTIVE MEMBERS		
R	Chiaramida, Joseph	2063 W. Ninth St., Brooklyn, N. Y.	Essex	
N	Cohan, Henry H.	911 Hill Top Rd., Riverton	Burlington	General
N	Demidov, Alexander P.	Jones Rd. & Route 9, Forked River	Ocean	Int Med
N	Finkel, Marion J.	Merck & Co., Rahway	Essex	Ind
N	Haase, F. Robert	601 Grand Ave., Asbury Park	Monmouth	Otolar
N	Rowe, William A.	Bayway Refinery, Esso Standard Oil Co., Linden	Union	Ind
N	Tullis, John L.	Overlook Hosp., Summit	Union	Path
R	Wurts, Margaret M.	27 Wellesley Ave., Upper Montclair	Essex	General
		ASSOCIATE MEMBERS		
	Bych, M. Merrell	186 Gregory Ave., Passaic	Passaic	Medicine
	Ciavarra, Vincent A.	222 Mt. Prospect Ave., Newark	Essex	Resident
	D'Ambrosio, Victor	1035 B Sheridan Ave., Elizabeth	Union	Resident
	Davis, Nancy DuM.	Muhlenberg Hosp., Plainfield	Union	Int Med
	Donahue, John K.	Georgetown University Hosp., Washington, D. C.	Union	Surg
	Doyle, Michael J.	US Army Hosp, Disp No. 7, Camp Kilmer, New Brunswick	Monmouth	General
	Faraoniw, Bohdan	272 Brookside Ave., Trenton	Mercer	Resident
	Foster, Edmund A.	211 E. State St., Trenton	Mercer	General
	Gatto, Philip	158 E. Grand Ave., Rahway	Union	Resident
	Haynes, William F., Jr.	163 Nassau St., Princeton	Mercer	Int Med
	Ignaccolo, Emanuele	321 E. 26th St., Paterson	Passaic	General
	Keene, Robert J.	2176 Pennington Rd., Trenton	Mercer	General
	Lofaro, Joseph J.	241 Oakdene Ave., Cliffside Park	Bergen	General
	Norton, Lawrence A.	Wood Rd., Morristown	Morris	General
	Portnow, Stanley L.	179 Crestwood Dr., South Orange	Essex	Resident
	Poulos, Peter P.	27 S. Ninth St., Newark	Essex	Thor. Cardio Vas Surg
	Pugliese, Agostino	501 S. 19th St., Newark	Essex	
	Ryan, Walter M., Jr.	601 Grand Ave., Asbury Park	Monmouth	Plas. Recons Surg
	Schneider, David	95 Washington St., East Orange	Essex	Resident
	Schummer, Tatjana	151 Cummings Ave., Trenton	Mercer	General
	Symonds, Francis C., Jr.	404 Tenafly Rd., Tenafly	Bergen	Plas. Recons Surg
	Truchly, George	541 E. Broad St., Westfield	Union	Orth Surg
	Vail, Adele S.	45 Hobart Ave., Short Hills	Essex	
	Wolarsky, Jacob	47 Recter St., Millburn	Essex	Resident
	Zingarini, Mario L.	1420 Greenwood Ave., Trenton	Mercer	General

County Society Reports • • •

Mercer

The *Mercer County Component Medical Society's* annual outing was held at the Trenton Country Club's Grove, Thursday afternoon, June 9.

The affair was under the direction of Dr. Joseph R. Burns, chairman, Entertainment Committee, with the assistance of committee members Drs. William H. Coleman; J. Albert deBlois; and Marvin Friedmann.

The Society's guests included members of the Society of Mercer County Pharmacists; State Senator Sido L. Ridolfi; Charles R. Howell, Commissioner of Banking and Insurance; Arthur J. Holland, Mayor of Trenton; Robert M. Backes, general counsel to The Medical Society of New Jersey; James A. Waldron, Chairman, Mercer County Bar Association's Medico-Legal Committee; Dr. Lloyd A. Hamilton, Trustee, The Medical Society of New Jersey; and Richard I. Nevin, Executive Officer, The Medical Society of New Jersey.

Prizes were awarded at the conclusion of a brief business session conducted by Dr. Peter J. Warter, President.

I. FRANK BIRD, M.D.
Reporter

Middlesex

Dr. John A. Smith presided over the regular monthly meeting of the *Middlesex County Medical Society* at Roosevelt Hospital, Metuchen, May 25.

The Judicial Medical Ethics Committee (Dr. B. F. Slobodien, Chairman) recommended the applications to the Credentials Committee of The Medical Society of New Jersey for election to Regular membership from Associate membership of H. Stephen Brody, M.D., New Brunswick; and two years' associate membership for Drs. Daniel W. Colburn, Spotswood and Marvin S. Eiger, New Brunswick.

The guest speaker, Charles Korn, Counselor-at-Law, gave a resumé of possible pitfalls in estate planning. He strongly recommended seeking legal advice followed by periodic reviews of the plan.

Dr. John A. Smith, the president, announced that The House of Delegates rejected the resolution on "The Funded Eye Care Plan," and the change in representation in Board of Trustees. Blue Shield riders for diagnostic x-rays and pathologic examinations in and out of hospitals were accepted.

Collation was served.

THOMAS I. STEINBERG, M.D.
Reporter

Monmouth

A meeting of the *Monmouth County Medical Society* was held at Fitkin Memorial Hospital on May 25. The scientific portion of the program was conducted by Dr. Herbert Kupperman, Professor of Medicine, New York University College of Medicine who spoke on "Recent Advances in Endocrinology."

The business meeting, conducted by Dr. Lester A. Barnett, was called to order at 10:30 p.m. A proposed amendment to the constitution was read changing the requirements of associate membership from 1 to 2 years and requiring compulsory attendance on emergency medical services. This was not acted on because the quorum required for consideration of an amendment was not present.

A proposal to assess $25 per member for the work of the public relations committee was discussed. Dr. Donald Bowne, Chairman of the Public Relations Committee, indicated that this would be spent primarily for newspaper advertisements, but also to help support the expanded emergency medical service. A suggestion was made to use currently available funds and then to assess the members further if funds were needed. The proposal was postponed for consideration at a later meeting.

Dr. Daniel Featherston was commended on his election as treasurer of The Medical Society of New Jersey. Dr. Featherston reported on the action of the Trustees relative to the Blue Cross proposal for a diagnostic rider for work in outpatient departments of hospitals. The Trustees of The Medical Society of New Jersey are opposed to this diagnostic rider on the Blue Cross but support the diagnostic rider for the Medical-Surgical Plan.

The Emergency Service Program was discussed by Dr. Rifici. He noted that only 85 physicians have volunteered thus far to participate in the program. He stressed the importance of more attendance in this extremely valuable piece of public relations so that this public service can be effectively carried out.

LEONARD S. DANZIG, M.D.
Reporter

Passaic

The annual meeting of the *Passaic County Medical Society* was held on May 24, at 9:00 p.m. at the Medical Society Building. The meeting was presided over by Dr. Julian Cohen, President.

Drs. M. Merrell Bych of Passaic and Emanuele Ignaccolo of Paterson were elected to Associate membership.

Resolutions on the death of four members of the

Society, Dr. David Carlough, Dr. David Crounse, Dr. Herbert Katz, and Dr. Nathan Salzman, were read and adopted.

The President reported that the members of our County who have received the Golden Merit Award this year, for having completed fifty years of practice were: Drs. Theodore Bender, Walter M. Winters and Arey A. Butterfield.

It was also reported that Dr. Joseph Jehl was re-elected to the Board of Trustees of The Medical Society of New Jersey for a three-year term.

Dr. Cohen then called upon Dr. Theodore K. Graham, Chairman of the Nominating Committee who read the report of the committee as follows: President—F. Albert Graeter, M.D.; First Vice-President—David B. Levine, M.D.; Second Vice-President—Francis R. Meyers, M.D.; Secretary—Marion F. Kaletkowski, M.D.; Treasurer—Frank B. Vanderbeek, M.D.; Assistant Treasurer—James A. Rogers, M.D.; Reporter—Irving Chrisman, M.D.; Board of Censors (3 years)—Julian Cohen, M.D.; Building Trustees (3 years)—Samuel J. Della Penna, M.D., Morris H. Saffron, M.D., Raphael R. Goldenberg, M.D. and Joseph R. Jehl, M.D.

The President called for nominations from the floor. There being none, it was agreed that nominations be closed, a ballot cast, and the panel unanimously elected.

Dr. Cohen expressed appreciation to the officers and members for their cooperation and interest in the activities of the Society during his administration. He introduced the new president, Dr. F. Albert Graeter. Dr. Graeter thanked the members for the honor bestowed upon him.

The meeting was then turned over to Dr. C. T. Reilly who introduced the guest speaker, Edward C. Mann. Assistant Professor of Clinical Obstetrics and Gynecology, Cornell University Medical College. Dr. Mann's subject was "The Role of Uterine Isthmus in Cervical Incompetence and Habitual Abortion." A question period followed.

At the conclusion of the scientific program, a collation was served by Mrs. Irving Hayman, Chairman of the Hospitality Committee of the Woman's Auxiliary.

IRVING CHRISMAN, M.D.
Reporter

Obituaries • • •

DR. EMERY BOKOR

Dr. Emery Bokor, a general practitioner in Newark for 35 years, died on May 12, after a cerebral hemorrhage. Born in Hungary in 1888, he was graduated from the medical school of the University of Budapest in 1911 and came to the United States in 1924. He settled in Newark, and did family and general practice in that city until his death. Dr. Bokor was especially interested in cardiology and internal medicine and was affiliated with that service at the Newark Beth Israel Hospital.

DR. OSCAR GLASS

Dr. Oscar Glass, born in Austria in 1895, died at his home in East Orange on May 10. He received his M.D. degree in 1922 at the medical school of the University of Vienna, interned in Germany in 1922-23 and came that year to the United States where he settled in Newark. He served a residency at St. Michael's Hospital in that city, and then entered private practice. He became increasingly interested in gynecology, and eventually became chief of that service both at the Beth Israel Hospital and at St. Michael's Hospital. He was a diplomate of the American Board of Obstetrics and Gynecology and an F.A.C.S. Dr. Glass was one of the founders of the American College of Obstetrics and Gynecology. He was, at one time, vice-president of the Beth Israel Hospital medical staff.

DR. DAVID P. LIEBERMAN

A heart attack on May 16 took the life of Dr. David P. Lieberman, a well-known Elizabeth pediatrician and a member of his city's Board of Education. Born in New York City in 1903, he won his M.D. degree at Bellevue in 1928. After internship he moved to Elizabeth, New Jersey, and served the people of that area for 20 years thereafter. He became affiliated with St. Elizabeth's Hospital and with the Elizabeth General Hospital, passing through all grades, eventually becoming senior attending pediatrician at both institutions. He was

secretary of the medical board at Elizabeth General and director of pediatrics for the city Board of Health. A trustee of Temple B'Nai Israel, he also had served as president of the local YMHA.

DR. JOSEPH E. MOTT

Dr. Joseph E. Mott, for the last 18 years a member of our Publication Committee, died on May 24, at the untimely age of 53. Dr Mott was en route to a meeting of the Passaic County Medical Society when he was stricken with his fatal coronary attack.

A native of Paterson, he was graduated in 1931 from Bellevue and interned at Paterson General Hospital. Dr. Mott was an obstetrician and gynecologist. He was Associate Attending Obstetrician at St. Joseph Hospital in Paterson. During World War II, he was a lieutenant commander in the Navy and had three years of active sea duty in the Pacific. At one time he was a member of the Paterson Board of Health.

Dr. Mott was active in organized medicine. He served as Public Relations Chairman of The Medical Society of New Jersey, editor of the Passaic County Medical Society *Bulletin*, chairman of the Community Chest's Health Division, president of the Clinical Society of St. Joseph Hospital, and a director of the New Jersey Welfare Board. He also had long service as Secretary of the Passaic County Medical Society.

DR. SAMUEL H. SCHWARTZ

Bound for Nassau on a vacation cruise, Dr. Samuel H. Schwartz of Plainfield, suffered a fatal heart attack on May 8 on the ship, and was flown to a hospital in Albemarle, N. C., where he died. A diplomate in internal medicine, he was senior attending physician at the Muhlenberg Hospital. Dr. Schwartz established the electrocardiography department at that hospital.

Born in New York City in 1902, he was graduated in 1927 from the medical school of Boston University. He came to Plainfield to intern at Muhlenberg and liked the city well enough to make this his home for the rest of his life. He was a medical corps major in World War II, and an F.A.C.P. He was a trustee of the New Jersey Heart Association and had been president of the Union County Heart Association. He was a director of the Jewish Community Center in Plainfield.

DR. ANNE LARDNER SHANNON

One of Montclair's best known surgeons, Dr. Anne Lardner Shannon died on May 5. Born in North Carolina in 1898, she obtained her M.D. degree at Cornell in 1924. She then did graduate work in ophthalmology and otolaryngology in Vienna, and interned at Grasslands in Westchester County, N. Y. Dr. Lardner Shannon (as she was generally known) was a diplomate in Otolaryngology and was attending surgeon in that specialty at Mountainside and Montclair Community Hospitals. She served a term as vice-president of the Montclair Board of Education. She was an F.A.C.S. and a member of the Daughters of the American Revolution.

DR. MORRIS J. WEISS

One of Bayonne's civic leaders, Dr. Morris J. Weiss, died suddenly on May 15 at his home in that city. Born in New York City in 1889, he was brought to Bayonne in infancy, and returned there after earning his M.D. degree at Bellevue in 1913. He interned in 1913-4 at the Bayonne Hospital and became affiliated with the ear-nose-throat service there on conclusion of his internship. Three years later he was commissioned in the medical corps of the U. S. Army and on being discharged from military service in 1919, he remained in Europe for graduate study of otolaryngology in Austria. On return to New Jersey, he became chief medical examiner for the Bayonne Board of Education and served the Bayonne Hospital's otolaryngologic service in all grades from clinical assistant to chief. He was president of that hospital's medical board in 1951 and 1952. He was vice-president of the local Jewish Community Center and on the national board of directors of the Conference of Christians and Jews. He was a trustee of the Broadway National Bank in Bayonne.

NOTE TO READERS

The annual reports and transactions of the House of Delegates are bound together in this issue of THE JOURNAL.

Actions taken by the House of Delegates are indicated in bold face type in the reports.

The other activities of the annual meeting will be published periodically in THE JOURNAL and will be identified in the table of contents of each issue in which they appear, as well as in the index of the year.

INDEX

Administration of Public Medical Care . . 370
Aeromedical Evacuation Transport Service Resolution . . . 415
Allman, David B., Resolution . . . 419
Annual Meeting Committee . . . 379
Assembly Bill 556 Resolution . . . 418
Assembly Bills 556, 612, and 60 Resolution . . 421
Budget . . . 383
Bylaws Amendments . . . 392
Cancer Control Committee . . . 403
Child Health Committee . . . 404
Chronically Ill and the Aging Committee . . . 405
Conflicting Policy Actions . . . 364
Conservation of Hearing and Speech Committee 405
Conservation of Vision Committee . . . 406
Constitution and Bylaws Revision Committee . 393
Constitutional Amendments . . . 389, 391
Contact Lenses . . . 370
Cosgrove, Samuel Allison, Memorial . . . 422
Costello, William F., Resolution . . . 419
Credentials Committee . . . 381
Disaster Medical Services Committee . . . 408
Drugs, Use by Non-medical Personnel . . . 370
Dues . . . 383
Election . . . 444
Emeritus Membership Nominations . . . 423
Executive Officer's Report . . . 378
Eye Care on a Funded Basis . . . 369, 414
Finance and Budget Committee . . . 383
Fund Raising Organizations Resolution . . . 420
Health Care of the Aged . . . 364
Health Officer Resolution . . . 416
Honorary Membership Committee . . . 384
Hospital Service Plan—
Diagnostic Cystoscopies . . . 368
Paid-up Policies in . . . 365
Rider for Diagnostic Services . . . 372, 421
Industrial Health Committee . . . 402
Interns Resolutions . . . 411, 413
Intravenous Medication by Nurses . . . 368
Judicial Committee/Council Records Resolution 422
Judicial Council Report . . . 373
Legislation, Administrative Council on . . . 395
Major Medical Insurance for Physicians Resolution . . . 413
Maternal and Infant Welfare Committee . . . 406
Medical Defense and Insurance Committee . . . 384
Medical Education Committee . . . 386
Medical-Legal Testimony . . . 368
Medical Service Administration Report . . . 424
—Board of Governors Nominations . . . 373
Medical Services Administrative Council . . . 397
Medical Student Loan Fund Committee . . . 387
Medical-Surgical Plan Report . . . 427
—Apportionment of Fees Resolutions . . . 411, 414
—Board of Trustees . . . 366
—Board of Trustees Nominations . . . 372
—Chiropodists, Payment to . . . 365
—Dental Oral Surgeons, Payment to, Resolution . . . 417
—Paid-up Policies in . . . 365
—Public Relations Counsel . . . 365
—Riders Resolution . . . 420
—Riders for Diagnostic Services . . . 372, 421
Medicare Program . . . 365
Mental Deficiency, Director of State Division . . 370
Mental Health Committee . . . 407
Nominating Committee Report . . . 444
Nurses Training . . . 371
Optometrists . . . 370
Physicians Placement Service . . . 410
Practical Nurses . . . 371
President's Address (Bowers) . . . 447
President's Report . . . 357
Professional Liability Insurance . . . 366
Publication Committee . . . 388
Public Health Administrative Council . . . 399
Public Relations Administrative Council . . . 401
Reference Committees—
"A" . . . 432
"B" . . . 433
"C" . . . 434
"D" . . . 436
"E" . . . 437
"F" . . . 439
"G" . . . 440
Constitution and Bylaws . . . 441
Rehabilitation Committee . . . 408
Relative Value Index . . . 397
Representation in House of Delegates Resolution . . . 410
Resolutions (indexed by subject) . . . 410
Retirement Plan for Physicians . . . 366
Revision of Constitution and Bylaws Committee 393
School Examination Law—Amendment . . . 373
Scientific Exhibits Committee . . . 380
Scientific Program Committee . . . 380
Secretary's Report . . . 362
Social Security for Physicians . . . 369, 412
Staphylococcal Infections in Hospitals . . . 371
Technical Services by Non-Professional Personnel Resolutions . . . 417, 419
Traffic Safety Committee . . . 409
Transactions, 1959, Approval . . . 448
Treasurer's Report . . . 359
Trustees' Report . . . 363
Utilization of Hospital Facilities . . . 370
Woman's Auxiliary Advisory Committee . . . 388
Workmen's Compensation Committee . . . 403

Official Transactions of the House of Delegates

194th ANNUAL MEETING OF THE MEDICAL SOCIETY OF NEW JERSEY

HADDON HALL, ATLANTIC CITY, N. J.

MAY 14 - 18, 1960

ANNUAL REPORTS

President

(Reference Committee "A")

F. Clyde Bowers, M.D., Mendham

Your President submits his annual report with mixed feelings of pride and regret. The administration is proud of its modest accomplishments but regrets that it was unable to achieve more within the time allotted.

It might be well at this point to pause and analyze the amount of work done by The Medical Society of New Jersey with its 13 full-time office personnel and its more than 50 active committees involving some four hundred physician-members. The total operation requires an annual budget of close to $200,000, but the expenditure would be many times this amount if each physician participating in the activities of the Society were compensated.

During the year as President I have traveled some 17,000 miles and have spent 1,400 hours in the performance of official duties. This activity has included traveling around many parts of the United States and most of New Jersey. I have visited more than half of the counties, speaking in most of them. It has been my privilege to represent The Medical Society of New Jersey at many important functions, including two college presidential inaugurations, two other state society conventions, many annual meetings of other medical and non-medical groups, state and national governmental committees, and seminars covering various medical subjects. Monthly meetings of the Board of Trustees of The Medical Society of New Jersey, of the Medical-Surgical Plan of New Jersey, and of the Hospital Plan of New Jersey were attended, as well as special meetings of liaison groups and other special committees. I would not hazard a guess at the time spent on the telephone, writing letters, or attending incidental meetings.

I do not cite the above activities with any notion of bewailing my fate, of seeking sympathy, or of appearing as a martyr for organized medicine in the State of New Jersey. These are duties expected of and performed by each President of The Medical Society of New Jersey each year. Anyone who is unwilling to make these sacrifices should not seek the office in the first instance. For me, it has been a great honor and a great privilege. I do not regret one moment of it. To paraphrase Nathan Hale, I regret that I have but one life to give to my profession.

Early in the administrative year an unsuccessful attempt was made to get the Commissioner of Motor Vehicles to lift the extra charge for M.D. license plates. Although many of my colleagues have seen fit to pay the special fee, I still feel that as invited guests we should not be expected to pay for our dinners.

More successful, however, was our effort to obtain from the Attorney-General a favorable ruling on the administration of intravenous therapy by graduate nurses. After five years of bickering and controversy it was finally agreed that certain graduate trained nurses who were approved by the physician for such duty would be permitted to give intravenous medications.

The big issue of the year—and probably for some time in the future—has been the medical care of the aged and aging. This has been—and still is—being studied, fought, analyzed, and compromised at state and national level. At national level the Forand Bill—which is no solution to the problem—has been kept in committee twice within the year through the

efforts of organized medicine and many of our friends, especially the Chamber of Commerce. For further study of the problem there has been organized a state committee for the White House Conference on Aging in 1961, of which your President is a member. We have also established a Joint Council to Improve the Health Care of the Aged, patterned on the National Council. At state level our Medical-Surgical Plan has been considering the possibility of making available the basic contract for those over 65, and we are still attempting to effectuate a special contract for these aged people. The signature of about 6 per cent more participating physicians will allow the later contract to become a reality.

For the first time in many years a special meeting of the House of Delegates was held because of the vital matter of the proposed issuance of diagnostic riders on Blue Cross contracts. As you know, a concomitant rider for diagnostic studies by Blue Cross and Blue Shield was overwhelmingly defeated. Furthermore, the House authorized the President to appoint a committee to approach the Commissioner of Banking and Insurance and voice our opposition to a Blue Cross rider for diagnostic services.

At the time of this writing, your Society is busily engaged in an all-out effort to defeat Assembly Bill 556 which, if it becomes law, would place in the hands of the Banking Commissioner full power to set physicians' fees.

After three years of concentrated and detailed study the Council on Medical Services is prepared to offer to this year's House of Delegates a Relative Value Index. These are being adopted in many states with many variations but *not* without considerable debate and opposition on the part of some physicians. Our council has done an excellent job and has, what appears to be, the best possible plan.

The Conservation of Vision Committee has worked diligently on preparing a brochure for the eye health care of the school child which will be available in every school district in the state. This should prove very helpful in ascertaining and treating many eye defects, and consequently preserving the vision of many children heretofore overlooked and neglected.

Much work is being done in the mental health field. There is soon to be appointed a Director of the State Division of Mental Deficiency who will expedite the handling of mental health problems. Also proposed and presently being reviewed by a special committee of the State Society are revisions in our present law regarding the prosecution of the criminally insane and the commitment of the mentally ill.

During the year a special committee, as well as the standing committee on Medical Defense and Insurance has been interviewing other insurance carriers and investigating means of bettering our protection. It is hoped that a worthwhile proposal will be made to the 1960 House of Delegates.

Many improvements were made to our headquarters building, including a ladies' powderroom on the second floor, furnishing of a Presidential Suite on the third floor, toilet facilities in the Trustees' room and other minor repairs.

The year has been a busy one, albeit a pleasant one. Whatever success the present administration has had has been due to the wonderful cooperation of the staff, the presidential officers, the Board of Trustees, and the many willing committee members. To them all, I am eternally grateful.

Adopted (page 432)

Treasurer

(Reference Committee "B")

RUDOLPH C. SCHRETZMANN, M.D., Bergenfield

A complete annual report cannot be submitted at this time as the fiscal year does not close until May 31, 1960. An interim report covering the accounts from June 1, 1959, through April 13, 1960, is presented below:

BALANCE SHEET — APRIL 13, 1960

ASSETS

Cash:		
First Trenton National Bank:		
General Checking Account	$221,257.40	
Executive Office Revolving Account	7,061.78	$228,319.18
Savings Accounts:		
Bloomfield Savings Bank, Bloomfield	$ 10,000.00	
Howard Savings Institution, Newark	10,000.00	
Morris County Savings Bank, Morristown	7,281.58	
Montclair Savings Bank, Montclair	10,000.00	
Plainfield Trust Company, Plainfield	5,333.78	42,615.36
Savings and Loan Accounts:		
Guardian Savings and Loan, Atlantic City	$ 10,000.00	
Midtown Savings and Loan, Newark	10,000.00	
Monroe Savings and Loan, Newark	10,000.00	
Police Savings and Loan, Newark	10,000.00	
Roma Savings and Loan, Trenton	10,000.00	50,000.00
Total Cash		$320,934.54
Accounts Receivable		11,670.26
Inventory Maternal Welfare Record Books, at cost (contra)		218.27
Investments—U. S. Savings Bonds		26,500.00
Land, Buildings, and Equipment (contra)		145,812.29
Total Assets		$505,135.36

LIABILITIES, RESERVES, AND SURPLUS

Employees' Payroll Deductions	$ 2,384.09
A.M.A. Dues Payable	1,025.00
Assessments Collected, Applicable to 1960-61	116,598.62
House Reserve	1,348.50
Annual Meeting Reserve	29,027.07
Membership Directory Reserve	9,396.93
Journal Reserve	7,323.34
Unexpended Budget Accounts, 1959-60 fiscal year	24,729.99
American Medical Education Foundation	28,555.82
Extraordinary Legal Reserve	5,000.00
Land, Buildings, and Equipment Reserve (contra)	145,812.29
Maternal Welfare Record Books Reserve (contra)	218.27
Surplus	133,715.44
Total Liabilities, Reserves, and Surplus	$505,135.36

STATEMENT OF RECEIPTS AND DISBURSEMENTS FOR FISCAL YEAR 1959-60

JUNE 1, 1959 — APRIL 13, 1960

RECEIPTS — GENERAL FUND

Cash Balance, June 1, 1959					$130,630.19
Assessments:	AMA Dues	AMEF	State Dues	Total	
Atlantic County	$ 3,775.00	$ 725.00	$ 5,255.00	$ 9,755.00	
Bergen County	12,000.00	2,936.80	20,746.40	35,683.20	
Burlington County	2,250.00	460.03	3,489.94	6,199.97	
Camden County	7,225.00	1,495.07	10,524.86	19,244.93	
Cape May County	750.00	155.00	1,085.00	1,990.00	
Cumberland County	2,225.00	470.00	3,290.00	5,985.00	
Essex County	31,600.00	6,788.55	48,831.23	87,219.78	
Gloucester County	1,800.00	360.00	2,520.00	4,680.00	
Hudson County	12,200.00	2,606.67	18,661.66	33,468.33	
Hunterdon County	1,100.00	223.34	1,563.32	2,886.66	
Mercer County	8,562.50	1,683.38	12,239.24	22,485.12	
Middlesex County	7,150.00	1,470.08	10,363.17	18,983.25	
Monmouth County	5,800.00	1,306.70	9,836.60	16,943.30	
Morris County	6,025.00	1,191.68	8,491.64	15,708.32	
Ocean County	1,650.00	305.00	2,285.00	4,240.00	
Passaic County	10,575.00	2,643.42	18,843.16	32,061.58	
Salem County	1,225.00	240.00	1,710.00	3,175.00	
Somerset County	2,475.00	480.00	3,715.00	6,670.00	
Sussex County	1,050.00	205.00	1,335.00	2,590.00	
Union County	13,800.00	2,715.10	19,697.46	36,212.56	
Warren County	875.00	175.00	1,255.00	2,305.00	
Total Assessments	$134,112.50	$ 28,635.82	$205,738.68	$368,487.00	
A.M.A. Dues Refunds				$ 212.50	
Journal Advertising, net				59,328.94	
Annual Meeting Exhibits				22,520.00	
Interest				4,672.63	
Sale of Maternal Welfare Books				1,019.73	
Payroll Deductions				2,384.09	
Refunds of Budget Expenses 1959-60				937.21	
Janitorial Services				10.00	
A.M.A. Dues Collection				140.12	
Medical Student Loan Fund—Transfer				12,000.00	
Membership Directory				4,412.60	
Refunds of Budget Expenses 1958-59				440.42	
House Committee Reserve				141.16	
Proceeds from U. S. Treasury Bills and Bonds				149,865.83	
Total Receipts					$626,572.23
Total					$757,202.42

DISBURSEMENTS

Budget Accounts:

A-1	Executive Salaries	$ 31,201.76
A-2	Executive Office Salaries	35,409.82
A-3	Executive Office Expenses	1,645 67
A-4	Executive Travel	1,850.77
A-5	House Maintenance	12,267.16
A-6	Treasurer	2,440.56
A-7	Committee on Finance and Budget	18.89
A-8	Secretary	523.81
A-9	Salary Taxes	1,512.08
A-10	Insurance	1,686.19
C-2	Council on Legislation	2,632.69
C-3	Council on Public Health	1,177.58
C-4	Council on Public Relations	6,024.18
C-5	Council on Medical Services	828.21

D-1	President and Presidential Officers	2,668.44	
D-2	A.M.A. Delegates	7,186.18	
D-3	Advisory Committee to Woman's Auxiliary	5,856.56	
D-4	Committee on Medical Education	195.47	
D-5	Liaison Committees	124.42	
D-6	Directory, Membership, Physicians Placement	12,449.37	
D-7	Committee on Disaster Medical Services	18.88	
D-11	Committee on Medical Defense and Insurance	91.37	
E-1	Board of Trustees	1,639.05	
E-2	Contingent	5,695.58	
E-3	Judicial Council	2,064.78	
E-4	Legal	5,133.49	
E-6	Medical Student Loan Fund	5,000.00	
	Total Budget Accounts		$147,342.96
	Accounts Payable, May 31, 1959		2,231.13
	Journal Publication		55,174.52
	Journal Office Expenses		425.07
	Journal Travel		16.97
	Journal Commissions		3,651.86
	Annual Meeting		5,370.82
	Janitorial Services		100.00
	A.M.A. Dues Collection		236.25
	Assessments Refunded		855.82
	A.M.A. Dues		134,075.00
	House Reserve		9,947.37
	Budget Expenses for 1958-59		453.29
	Medical Student Loan Fund—Transfer		16,097.18
	Journal Reserve		816.64
	Purchase of U. S. Treasury Bills		49,470.00
	American Medical Education Foundation		10,000.00
	Reserve for Membership Directory		3.00
	Total Disbursements		$436,267.88
	Cash Balance, April 13, 1960		320,934.54
	Total		$757,202.42

SHORT-TERM INVESTMENTS

As recommended by the House of Delegates a few years ago, short-term investments have been made from the general fund as market conditions and the balance in the checking account have permitted. This procedure will be continued.

Adopted (page 433)

Secretary

(Reference Committee "A")

MARCUS H. GREIFINGER, M.D., Newark

The office of the Secretary has dealt with routine matters involving correspondence, telephone inquiries, and completion of questionnaires from many sources.

The Secretary attended the annual meeting of the American Medical Association in Atlantic City, as well as the meetings of the Board of Trustees and the several committees of which he is chairman, member, or advisor.

MEMBERSHIP

(as of December 31, 1959)

Active: Paid	5,975	
Exempt	241	6,216
Associate		252
New and reinstated members		321
Members deceased		64
Transfers in state		26
Transfers out-of-state and resignations		35
State Emeritus		134
State Honorary		4
Members dropped for non-payment of dues		58
A.M.A. Members		5,704

A.M.A. MEMBERSHIP

Although the annual membership growth of The Medical Society of New Jersey results in an increased New Jersey A.M.A. membership, this expansion has not reached a point which would allow New Jersey an additional delegate. The A.M.A. delegation continues to total six, based on our present A.M.A. membership of 5,704—one delegate per 1,000 members or fraction thereof.

MEMBERSHIP DIRECTORY

The 1959-60 Membership Directory, the fourth issue of publication, was mailed the week of September 14, 1959. Listings include members reported to the executive offices as of June 1, 1959. A change in format has resulted in a lower publication cost which will be reflected in future editions, since the cost of the change-over is included in the overall cost of the current edition. 6,202 copies were distributed without charge to the membership, and the balance has been sold. The supply of the current edition is exhausted.

The fifth edition is scheduled for publication and distribution in the summer of 1961.

VACANCIES IN THE HOUSE OF DELEGATES

The following report concerning delegates who did not attend the majority of the sessions at the 1959 annual and 1960 special meetings was submitted to the Board of Trustees at its meeting on March 20, 1960. The Board of Trustees approved the report and the recommendations contained therein.

Of the 125 delegates who did not attend the majority of the sessions of the House of Delegates at the 1959 annual meeting, 73 did not attend the special session on March 13, 1960. This may cause 73 vacancies in the delegations of the component societies.

Article IV, Section 4 of the Constitution provides:

> A vacancy shall exist in the delegation of any component society whenever one (1) of its delegates ceases to be in good standing, or neglects to attend a majority of the sessions of the House of Delegates at two (2) consecutive meetings (annual or special). When such a vacancy occurs, the component society shall fill the unexpired term.

In determining the status of the 73 delegates who did not attend "a majority of the sessions of the House of Delegates at two (2) consecutive meetings (annual or special)" an opinion from the Society's Counsel was requested. Mr. Backes replied as follows:

> I have been asked an opinion concerning the meaning of the words "neglects to attend" found in Article IV, Section 4, paragraph (d), of the current Constitution of The Medical Society of New Jersey. The similar portion of the old Constitution reads "fails to attend" where the amended Constitution currently reads "neglects to attend."
>
> Winston's dictionary defines neglect as follows: "to fail to do, by carelessness or design."

The intention of the constitutional convention in recommending the word change referred to above was to lessen the impact of non-attendance, i.e., to waive the creation of a vacancy in the case where failure to attend a majority of the sessions of the house at two consecutive meetings (annual or special) was not through carelessness or design of the delegate.

It is my opinion, therefore, that both the definition of the word neglect and the intention expressed at the time of the change made indicate that a vacancy is not created in a component society's delegation where there has been no carelessness or design in failing to attend on the part of any delegate.

It is recommended:

1. That those delegates whose absence from the majority of the sessions of two consecutive meetings of the House of Delegates was in the view of the Secretary of this Society not due to carelessness or design, be regarded as acceptable accredited delegates for the next meeting of the House of Delegates;

2. That personal illness, death in the immediate family, religious objections, and other valid reasons be accepted by the Secretary;

3. That the burden of proof be placed on the individual delegate to justify his absence to the Secretary of this Society by completion and prompt return of a proper form; and

4. That component societies be notified as soon as practicable of the creation of vacancies in their delegation because of demonstrated "neglect to attend" upon the part of any of their delegates.

Communications were sent to the 73 physicians who did not attend the majority of the sessions at the last two consecutive meetings of the House of Delegates. Because of invalid reasons for not attending the meetings or failure to make a reply, 20 were declared ineligible to serve as delegates to the 1960 annual meeting.

The Committee on Revision of Constitution and Bylaws reviewed the preceding report, and approved the procedure adopted as a necessary implementation of the relevant section of the Constitution (Article IV, Section 4).

Adopted (page 432)

Board of Trustees

LUKE A. MULLIGAN, M.D., Chairman, Leonia

(Reference Committee "A")

This report will highlight only the major business considered and acted upon by the Board of Trustees. Most of the Board's activities of the year have been published in THE JOURNAL. The Society's business has made extremely heavy demands upon the time of the Trustees. Eleven regular meetings will have been held by the annual meeting. In addition, the numerous Board committees have been called upon to meet frequently.

The Trustees have served loyally and diligently. The Board's activities, as will be noted from the following items, have been, in the majority of instances, concerned with specialized subjects, which are referred to other reference committees for consideration in connection with the main subjects to be considered by those reference committees.

Regularly the Board of Trustees has dealt with general matters brought to its attention—correspondence and resolutions from members, component societies, and outside organizations; appointment of representatives to local, state, and national meetings of concern to this Society; nomination of candidates to the State Board of Medical Examiners; consideration of and action on the reports and recommendations of the several standing committees and administrative councils and their special committees; cooperation with the departments of the State government, and with the allied professions—dentistry, pharmacy, nursing, legal, and hospital administration.

To insure that the position of the Board will be emphasized concerning significant matters contained in its report to the House of Delegates, the Board is presenting specific resolutions to the House dealing with such significant matters and setting forth the position of the Board. Such resolutions are referred to other reference committees for consideration in connection with the main topics of consideration.

In order to set forth the attitude and opinions of the Board on matters to be considered by the reference committees, the President, at the direction of the Board has assigned one or more members of the Board of Trustees to each reference committee

Adopted (page 432)

CONFLICTING POLICY ACTIONS

(Reference Committee "A")

On occasion a specialty society or a county medical society takes a policy action which is in conflict with the policy action of The Medical Society of New Jersey. Two such occasions arose this past year.

It is the opinion of the Board of Trustees, and the two medical organizations were so notified, that any medical organization that wishes to identify itself with organized medicine should not make policy decisions without at least first consulting the parent society, which in this state is The Medical Society of New Jersey. Medical organizations should keep this fact in mind, and they should consult with this Society before taking a policy position or acting on their own—particularly on legislative matters and on matters which have been adopted by the House of Delegates. Medical organizations are reminded that The Medical Society of New Jersey is the policy-making body for all physicians as members of organized medicine and does not speak for any branch of medicine alone.

Adopted (page 432)

HEALTH CARE OF THE AGED

(Reference Committee "C")

As its first item of business following the 1959 annual meeting, the Board of Trustees reviewed the following items on the subject:

1. The January 18, 1959, action of the Board in which it recorded its approval and support of the A.M.A. recommendations regarding special health insurance coverage for people over 65 years of age with modest resources and reduced incomes, and four recommendations thereon; which report was presented to the House of Delegates.

2. The action of the House of Delegates which referred the report back to the Board of Trustees for further study with power to act; and the objections of Reference Committee "C".

3. A report from Medical-Surgical Plan on the development of a contract for prepaid medical and surgical coverage for persons over 65 years of age.

Following several conferences with Blue Shield representatives, a special subscription contract was developed by Blue Shield, and approved by the Board of Trustees, for people over 65 having modest resources or low family income. The contract received the approval of the Department of Banking and Insurance. Letters were mailed to the membership, over the President's signature, soliciting the signatures of participating physicians for the new contract. Every effort has been expended by Medical-Surgical Plan and the Society's Board of Trustees to obtain the necessary 51 per cent of participating physicians. As of April 22, 1960, 12 counties have over 51 per cent, with the total for the State 48.6 per cent.

Public relations-wise it will stand the profession in good stead if it can be shown that the physicians of New Jersey are willing to reduce their fees to care for people over 65 in reduced circumstances.

To meet the objections that a number of persons over 65 can well afford the basic contract—which is not now available to those over 65—and the fact that even if a special policy is offered it will not be attractive to many of those persons whose incomes are above the stated income ceiling, the Board of Trustees recommended to Medical-Surgical Plan that with all possible speed it make available to those over 65 years of age the basic contract, with whatever actuarial adjustment is necessary. The Plan board directed that the age limit of 65 years be waived in the non-group offering of the present basic subscription contract of Medical-Surgical Plan, subject to appropriate underwriting regulations to be developed by the staff, and approval by the Department of Banking and Insurance. The Department of Banking and Insurance has disapproved of such a waiver.

The Hospital Association was requested to reconsider the Society's suggestion urging a Blue Cross contract for senior citizens, without prejudice, examining the situation fairly and truly. The Association agreed to do so. A letter was also sent to the A.M.A. recommending that it take steps to investigate—on a broad scale—the validity of the hospital administrators' claims concerning hospital costs, and the consequent impossibility of effecting any reductions in costs for hospital services rendered to persons over 65 in the circumstances specified. No further reports have been received on these two requests.

Adopted [split vote] (page 434)

MEDICARE PROGRAM

(Reference Committee "C")

The required work in connection with the medicare program this past year has diminished considerably. The special committee has continued to consider disputed claims and supplemental agreements to the contract. Only 19 disputed claims were considered, 17 of which have been satisfactorily settled, and two are still pending.

Certain types of care were restored to the program on January 1, 1960. As more funds are available it is expected that the program will be fully restored to its original coverage.

Adopted (page 435)

MEDICAL-SURGICAL PLAN PAYMENT TO CHIROPODISTS

(Reference Committee "C")

In accordance with the recommendation of the 1959 House of Delegates, the matter of payment to chiropodists (M.S.P. 1953 amendment to Enabling Act) was referred to the Council on Legislation for further consideration and report.

The following report, received from the Council on Legislation, was adopted by the Board of Trustees:

The council re-studied this item in accordance with the directive of the 1959 House of Delegates that there be further study and report on rescinding the 1953 amendment to the Enabling Act, which makes it mandatory for MSP to include chiropodists in the Plan. On recommendation of the council the Board took action (4/12/59) that the amendment to the 1953 Enabling Act not be repealed because the advantages enuring to the Society from *not* repealing the law in question far outweigh the possible benefits to some few if the law were repealed. The House indicated its dissatisfaction with the 1953 amendment and called attention to its action in 1958 requesting MSP to continue the limitation of its payments to those holding a full license to practice medicine.

The council reaffirmed its original recommendation, *not* to attempt repeal of the 1953 amendment. It pointed out that there would be danger of other groups' attempting to amend our corrective legislation for purposes of weakening or altering the Enabling Act to their advantage. There would likewise be danger that antagonists of medicine would seize upon an attempt to repeal the supplement to the Enabling Act as motivated by selfishness and venality, and as constituting a brash curtailment of benefits to subscribers with no concomitant reduction of premium costs. The council is therefore of the opinion that public relations-wise, it would be foolhardy to attempt to get the 1953 amendment repealed.

The Board approved the recommendation of the Council on Legislation that the Medical Society *not* attempt to repeal the 1953 amend- to the Enabling Act.

Adopted (page 434)

PAID-UP POLICIES IN BLUE CROSS-BLUE SHIELD

(Reference Committee "C")

The resolution adopted by the 1959 House of Delegates, calling for an investigation of the possibility of a withheld premium that would enable a subscriber to obtain a paid-up Blue Cross-Blue Shield policy upon retirement was referred to Hospital Service Plan and Medical-Surgical Plan for study and reply.

A report from Hospital Service Plan stated that the matter would be studied by the coordinating committee at the operating level of Blue Cross and Blue Shield, and that after such consideration the Society would be advised of the conclusion.

Adopted (page 434)

M.S.P. PUBLIC RELATIONS COUNSEL

(Reference Committee "C")

The Board of Trustees viewed with concern the unfavorable publicity released by Blue Cross regarding medical costs in New Jersey, and the fact that there was little or no

separation between hospital costs and medical fees. The Board noted that the same public relations counsel serves Blue Cross and Blue Shield, that 60 per cent of his salary comes from Blue Cross and 40 per cent from Blue Shield. His services are rendered on the basis of approximately 99 per cent to Blue Cross and only one per cent to Blue Shield. With the thought that a wider separation of policy of Blue Cross and Blue Shield should be made to protect the medical profession and The Medical Society of New Jersey, and to prevent the blame for increased costs being laid in the lap of the medical profession, the Board of Trustees recommended to Blue Shield that it engage its own public relations counsel, not a physician, with salary to be paid completely by Blue Shield. He would be responsible exclusively to the President and Board of Trustees of Blue Shield. The Trustees further recommended that the President of Medical-Surgical Plan require that spokesmen for the Hospital Service Plan make no public statements regarding Blue Shield policies and contracts—current or proposed—except with the consent and approval of Medical-Surgical Plan.

The first recommendation was defeated by a split vote of the Board of Trustees of Medical-Surgical Plan. The Board of Trustees of The Medical Society urged Blue Shield to reconsider its action to give this Society's opinion the weight that it should carry. Blue Shield replied that it was deeply concerned by the criticism although it was not in accord with the Medical Society with respect to the necessary steps to be taken in order to remedy the alleged shortcomings, and that the public relations office had been directed to report monthly on the steps taken by it to improve the public relations representation of Medical-Surgical Plan.

Adopted (page 434)

M.S.P. BOARD OF TRUSTEES

(Reference Committee "C")

It was the opinion of the Board of Trustees that the President of The Medical Society of New Jersey is no doubt in a better position to convey the thinking of this Society to Medical-Surgical Plan than any other medical representative on the Plan board. Thus it was recommended to the Board of Trustees of Medical-Surgical Plan that the Plan constitution be changed to grant the President of The Medical Society of New Jersey membership on the Plan board, with full privileges.

The recommendation was approved by Medical-Surgical Plan, and its bylaws amended to increase the number of trustees from 20 to 21, and to include as a trustee: "the President of The Medical Society of New Jersey who shall serve as a trustee during his respective term in office."

The nomination of Dr. Bowers as a trustee of Medical-Surgical Plan for the balance of his term as President of this Society was approved.

Adopted (page 434)

RETIREMENT PLAN FOR PHYSICIANS

(Reference Committee "D")

The study of the possibility of the establishment of a retirement plan for members of The Medical Society of New Jersey was continued by a small special committee. Several meetings were held and a group policy offered by Prudential was considered. It was the opinion of the committee that the policy offered nothing that the individual physician could not do or get for himself.

The Board approved a recommendation that the special committee continue its study.

Adopted (page 436)

PROFESSIONAL LIABILITY INSURANCE

(Reference Committee "D")

Last year the Board authorized the appointment of a special committee to study, on a long range basis, the problem of professional liability insurance so that in the future if it should develop that the present insurance carrier does not provide proper protection to every member of the Society entitled to it, a plan will be prepared and ready to provide the membership with proper protection. This special committee has held many meetings and conferences with insurance carriers.

Over a period of ten months the special committee has sought necessary information from the present carrier, United States Fidelity and Guaranty Company, and it was not until mid-April 1960 that part of the requested information was received. The carrier has not been cooperative.

The special committee obtained detailed in-

formation on types of policies offered by several insurance companies, as well as what the rates would be on specific proposals.

A group policy, which has the approval of the special committee, is under study by the Board of Trustees. The special committee has recommended adoption of the proposal. A supplemental report on the matter will be submitted to the House of Delegates by the Board, together with its findings and/or recommendations.

(Supplemental Report)

PROPOSED PROFESSIONAL LIABILITY INSURANCE AND LOSS CONTROL PROGRAM

(Reference Committee "D")

The Board of Trustees has reviewed and approved the proposed Professional Liability Insurance and Loss Control Program—submitted by the American Mutual Liability Insurance Company of Wakefield, Mass., and adopted by the special committee. The proposed Program is outlined below:

1. *Group Policy*

We will write a Master Policy for the State Society with individual certificates being written for each Society member who enrolls under the Master Policy.

2. *Rates and Classifications*

We will charge the same rates for the same classifications that you have been charged for your present individual policies.

3. *Cancellation Provision*

The normal ten (10) day cancellation provision will be extended to sixty (60) days' notice on the part of either the Company or the Society. In addition, each certificate will carry a fifteen (15) day cancellation provision, which means the Company has to give the individual Doctor fifteen (15) days' notice of cancellation. Under the group concept, the Society is interested in the effect any potentially undesirable member for insurance may have on experience and rates. However, the occurrence of a claim does not per se make any individual insured a poor risk for the future. This is a matter of complete cooperation between the Company and the Society.

4. *Coverage*

A. *Professional Liability*

The Master Policy planned provides coverage that is as broad as it is possible to buy to cover the Professional Liability —if the complaint alleges malpractice and the court finds the defendant guilty of personal malpractice or vicariously liable for the malpractice of another (not a partner) for whose acts or omissions he is responsible, the Company would both defend and pay under the policy. It is not our intent, however, to assume any liability for hospital or clinic operation as such. We do not intend to cover a hospital's liability.

B. *Premises Liability*

While not mandatory, it is strongly recommended that the Society adopt the Premises Liability portion (Part II) of the Group Policy. This is to avoid claims falling into "no man's land" between two insurance companies, because of questions of fact as to whether a claim arose from the action of the doctor or the condition of the premises (e.g. dizziness from treatment or slippery floor). By having *both* Professional Liability and Premises Liability coverages under the same policy, there is no question about who handles the claim.

In order that this be an equitable arrangement for both the members of the Society and American Mutual there are several conditions which we feel are fundamental to success.

1. *Loss Control Program*

We will need to be reassured in writing of the Society's intent to adopt in principle and to cooperate in fact with our recommended Loss Control Program. We will be unable to help you build a strong Group Insurance Program without this keystone.

2. *Enrollment*

Unless a majority of the doctors in the State, as well as in each County and District Society, enroll, it will be extremely difficult to make the Loss Control Program effective or to produce a sufficiently broad base of experience for the deter-

mination of rates. American Mutual will ask for a complete review of the situation at the end of eighteen months if less than fifty per cent of the members of the State Society are enrolled by that time.

3. *Rates*

As we have stated to you before, we have no confidence in the rates established by the National Bureau or in its classifications. We have agreed to use them, however, until the actual experience of the Group has enough validity to dictate what these should be. We repeat that all experience (loss information) developed by the Group will be available to the Society or its independent actuarial counsel. The rates and classifications will come from this experience. The rates could go down. More likely, however, the rates may go up. Unless the Society is willing to let its own experience determine the rates, which is inherent in the group concept, and furthermore willing to stay with the Company long enough for experience to fully develop, which will take about five years, American Mutual is unwilling to undertake the development expense and potential loss which could occur.

RECOMMENDATION

That the Professional Liability Insurance and Loss Control Program offered by the American Mutual Liability Insurance Company be adopted by the House of Delegates.

Adopted with recommendation that a libel and slander rider be favorably considered for the membership (page 436)

MEDICAL-LEGAL TESTIMONY

(Reference Committee "E")

1. Code for Physicians and Attorneys

The Interprofessional Code for Physicians and Attorneys, adopted by the 1959 House of Delegates, has been adopted by all component societies with the exception of Morris, which has it under consideration, and Cape May.

2. Impartial Medical Witnesses

In accordance with the resolution adopted by the 1959 House of Delegates, the Special Committee on Medical-Legal Testimony conferred with the Chief Justice of the Supreme Court regarding an impartial medical panel. Chief Justice Weintraub expressed his personal concern in the matter, as well as a need for a medical committee on whom the Judiciary could call for confidential opinion as to whether there is malpractice in a case or not, and his desire to see a panel of doctors and lawyers established to examine malpractice cases to determine their merit. He promptly appointed a special committee from the Court—Judge Clapp, Chairman—to meet with our special committee.

One joint meeting has been held and others are planned for the near future. A proposed plan for neutral medical testimony in divergent cases is being drafted for consideration at the next meeting. From the plan as finally adopted will be drafted a Preliminary Rule and explanatory memorandum for submission to and consideration for adoption by the Supreme Court.

Adopted (page 438)

DIAGNOSTIC CYSTOSCOPIES—H.S.P.

(Reference Committee "C")

Blue Shield has approved payment for diagnostic cystoscopies with ureteral dilatation and/or retrograde pyelogram when such services are the only services performed during an in-patient hospital admission. This action was made contingent upon similar actions being taken by Blue Cross.

At the request of Blue Shield, the Board of Trustees urged Blue Cross to include diagnostic cystoscopies in its contract. In reply Blue Cross stated that it would continue to pay claims where cystoscopic procedures are related to treatment only. However, inasmuch as diagnostic cystoscopies were not included in the Plan's present rate structure, the matter will have to be included as part of the consideration of any new subscription contract, the timing of which is presently uncertain.

Adopted (page 435)

INTRAVENOUS MEDICATIONS BY NURSES

(Reference Committee "E")

The State Board of Nurses' Examiners did not adopt a recommendation sent to it by the State Board of Medical Examiners in November 1958. This was to the effect that nurses could give intravenous medication at

the "specific direction" of a licensed physician. Confusion then arose in the minds of nurses, physicians, and hospital administrators. Realizing the critical need for a satisfactory settlement of the question for the good of the patients, and the responsibility of this Society to protect its physician-members against the jeopardy in which they were placed in view of the situation, the Board of Trustees requested the Attorney General for a decision. Conferences were held with representatives from the Nurses' Association, the Hospital Association, and the State Board of Medical Examiners in an effort to overcome the impasse. The Attorney General instructed the nursing representatives to reevaluate matters. The Board of Nursing adopted an amendment to its original resolution concluding that under certain circumstances the administration of intravenous therapy by registered nurses licensed by the Nursing Board shall be permitted on the following basis:

1. Intravenous therapy may be administered:

   a. At the direction of a licensed physician or surgeon of this state;
   b. By registered nurses licensed in this state where they have received a course of instruction in intravenous therapy and have been approved by the medical staff of hospitals of this state.

2. The following medications may be administered:
   a. Glucose
   b. Saline solution
   c. Vitamins
   d. Ringer's lactate solution
   e. Amino acids
   f. Antibiotics

3. A course in intravenous therapy shall be included in the basic curriculum of the approved schools of professional nursing of this state, and that such course shall be approved by the New Jersey Board of Nursing.

4. Under no circumstances shall practical nurses aides, orderlies, nurse technicians or any other limited category connected with the nursing profession be permitted to administer intravenous therapy.

5. Those registered nurses who have heretofore or may hereafter receive training prior to the establishment of an approved course in intravenous therapy in the basic curriculum of the approved schools of professional nursing of this state, be recognized as being qualified to continue to administer intravenous therapy in the permitted categories provided they receive the approval of the medical staffs of the approved hospitals of this state.

Adopted (page 438)

SOCIAL SECURITY FOR PHYSICIANS

(Reference Committee "E")

In accordance with the affirmative action taken by the 1959 House of Delegates favoring the inclusion of physicians under compulsory social security, the Board of Trustees instructed the New Jersey delegates to the A.M.A. to introduce a resolution in favor of social security for physicians at the A.M.A. 1959 annual meeting.

The New Jersey delegates introduced the following resolution:

Whereas, the House of Delegates of The Medical Society of New Jersey on April 27, 1959, by a majority vote, went on record as desiring the inclusion of the members of The Medical Society of New Jersey under social security on a compulsory basis; therefore be it

Resolved, that the AMA House of Delegates take cognizance of this fact and take such steps as may be necessary to achieve such inclusion of physicians under the federal program.

The resolution was defeated in the A.M.A. House of Delegates.

Noted with regret (page 438)

EYE CARE ON A FUNDED BASIS

(Reference Committee "F")

At the request of the Board of Trustees, the Special Committee on the Conservation of Vision conferred with union representatives who had requested the Society's cooperation in setting up a pre-financed medical care program for union members through union welfare funds. Conferences between the union representatives and the special committee were held, following which the committee recommended:

1. That the Board of Trustees approve in principle the development of an ophthalmologic plan to make available the services of diagnostic examination (including refraction) and initial treatment (including the prescription and provision of glasses) by physicians to members of unions interested on a funded, pre-financed basis.
2. That the Special Committee on the Conservation of Vision be authorized to develop a plan for a pilot project and report to the Board of Trustees.

After review of the original request and the report and recommendations of the special committee, the Board took favorable action.

Subsequently, the Board was informed that

the New Jersey Academy of Ophthalmology and Otolaryngology disapproved the report and recommendations of the special committee, and requested that the matter be reviewed on the basis of the Academy's disapproval. The Academy was notified that the Board's decision was not lightly made; that when The Medical Society of New Jersey, through the Board of Trustees or the House of Delegates takes an action in the interest of all its members that that action is not subject to review or evaluation by any specialty society as such. Specialty societies in New Jersey must realize that the interests of the Medical Society are the interests of all physicians—not of specialized groups—and that, as in the case of question, the matters are thoroughly investigated by committees of the Society, reports are rendered, and the Board of Trustees, after careful consideration of all of the elements involved, takes official action.

A suggested pilot plan, prepared by the special committee was reviewed by a committee of the Board. The reviewing committee could find no fault in the proposal and stated its belief that the plan will work to the benefit of ophthalmologists. The reviewing committee further stated that the opposition to such a plan by the New Jersey Academy of Ophthalmology and Otolaryngology is merely on the basis of "government" medicine, but the contents of the suggested pilot plan show no true evidence of this. Upon the recommendation of the reviewing committee, the Board of Trustees approved the proposed "pilot plan" as submitted by the Special Committee on the Conservation of Vision.

Referred back for further study; plan to be published and circulated to membership for detailed examination before any implementation is undertaken (page 439)

OPTOMETRISTS/CONTACT LENSES/DRUGS

(Reference Committee "F")

Two resolutions adopted by the 1959 House of Delegates were directed to the attention of the State Board of Medical Examiners. The first resolution, from Essex County, recommended that steps be taken to end the fitting of contact lenses and use of drugs by nonmedical personnel. The second resolution, from Cumberland County, recommended that the Society use every means at its disposal to bring about the prosecution and conviction of optometrists who use drugs or otherwise engage in the illegal practice of medicine.

In reply the State Board of Medical Examiners stated it was unable to take action of a general character in regard to the complaints submitted, but that the Board is willing to prosecute any individual or individuals who are violating the provisions of the Medical Practice Act, provided information adequate for prosecution is made available to the Board.

The reply, accepted by the Board of Trustees, was provided to the sponsors of the resolutions (Essex and Cumberland County Medical Societies) for their information.

Adopted (page 439)

DIRECTOR, STATE DIVISION OF MENTAL DEFICIENCY

(Reference Committee "F")

The trustees have been informed that the Board of Control had officially raised the Bureau of Mental Deficiency to Division level, and that before a director could be finally named the Civil Service Commission was required to specify the qualifications of a director. The Board of Trustees agreed that the director of the Division should be a medical doctor. Suggested qualifications for a medical doctor as a director of the Division of Mental Deficiency were submitted to the President of the State Civil Service Commission, who has accepted them with thanks stating that the suggestions will be given careful consideration before the requirements are set by the commission.

Adopted (page 439)

ADMINISTRATION OF PUBLIC MEDICAL CARE

(Reference Committee "F")

The recommendations of the New Jersey Commission to Study Public Medical Care were received with a request for support by this Society.

Without prejudice as to its stand on such implementing legislation as develops, the Board of Trustees approved in principle the recommendations of the Commission.

Adopted (page 439)

UTILIZATION OF HOSPITAL FACILITIES

(Reference Committee "F")

The Board of Trustees approved the Medical-Hospital Liaison Committee's recommen-

dation to the two parent organizations that a joint recommendation be made—by The Medical Society of New Jersey to medical directors, and by the New Jersey Hospital Association to administrators—that every hospital establish and maintain a "Committee on Admissions and Discharges." Accordingly, a communication was sent to the medical director of every New Jersey hospital requesting participation in the project and to do all that could be done to realize the establishment in each hospital of a committee of this character, if one such does not already exist. To assist in the realization of this objective, a copy of the brochure "Guide to the Establishment and Functioning of a Medical Staff Utilization Committee" was sent to each medical director.

Adopted (page 439)

STAPHYLOCOCCAL INFECTIONS IN HOSPITALS

(Reference Committee "F")

Both the Hospital Association and Nurses' Association have expressed an interest in a continuing program dealing with staphylococcal infections in hospitals. Last spring the Medical Society felt there was no need for further study, that it was under control. However, in view of the interest of the two associations, the Tri-Partite (Medical-Hospital-Nursing) Committee conferred on the matter.

The committee agreed that this is not a matter for public meetings. They recommended that, with the approval of the Medical Society and the New Jersey Hospital Association, steps be taken to encourage the establishment in all hospitals of committees for the control of staphylococcal infections in hospitals.

Adopted (page 439)

NURSES TRAINING

(Reference Committee "F")

Professional Nurses—The New Jersey Hospita Association took exception to several changes in the curriculum of hospital schools of professional nursing as proposed by the State Board of Nursing. If the proposals are adopted, it is feared that costs of operating hospital schools of nursing will be too great to be sustained. The Hospital Association requested conferences with the Medical Society on the matter. Prior to this, our representatives had met with the New Jersey Board of Nursing to discuss the revision of the curriculum for schools of nursing.

The following resolutions, adopted by the conference of representatives of hospital schools of nursing, were concurred in and approved by the Medical-Hospital Liaison Committee:

1. *Be It Resolved* that schools of nursing admissions requirements, set forth in the proposals of the State Board of Nursing, are too restrictive and should be restudied with the aim of permitting individual schools to exercise discretion in admitting students who do not meet the proposed minimum admission standards set forth by the State Board of Nursing.

2. *Be It Resolved* that the State Board of Nursing be asked to give further consideration to the addition of the two-year nurse training program of a required, one-year, salaried, internship to be served in an accredited hospital school of nursing.

3. *Be It Resolved* that the State Board of Nursing's proposal that evening or night clinical rotation for student nurses be limited to 40 days for the three-year training program be amended to permit the number of evening and night hours to be left to the discretion of individual schools of nursing, with the provision that there be adequate supervision of students on evening and night hours.

4. *Be It Resolved* that scheduling of class hours and their distribution over the three-year training program be left to the discretion of the individual schools of nursing.

5. *Be It Resolved* that the word "may" in the sixth general principle in the Nursing and Allied Arts Area (page 9) be changed to "should" so that the provision would read, "Principles of leadership and management should be included and principles of disaster nursing should be integrated in the content of Nursing and Allied Arts."

6. *Be It Resolved* that the State Board of Nursing be requested to make a statement of uniform policy on the subject of hospital schools of practical nursing, and that such schools be encouraged as a means of alleviating the nurse shortage.

Practical Nurses—Hospitals are concerned about training of practical nurses. The State Board of Nursing has control over the training of practical nurses. However, their rules are so elastic that the Board of Nursing can change them at will. As a result, it is feared that the number of nurses available in the future is being constantly threatened. Steps must be taken to insure proper nursing care for the patient and adequate nursing personnel. Further conferences with the Hospital Association are planned in this connection.

Referred back to Medical-Hospital Liaison Committee for further study and clarification (page 439)

(Supplemental Report)

MSP BOARD OF TRUSTEES—NOMINATIONS

(Reference Committee "C")

The following nominations for membership on the Board of Trustees of Medical-Surgical Plan of New Jersey for 1960-61, were approved by the Board of Trustees of The Medical Society of New Jersey and are referred to the House of Delegates for action:

Charles W. Barkhorn, M.D.
Irving P. Borsher, M.D.
Robert G. Boyd
Charles L. Cunniff, M.D.
Joseph P. Donnelly, M.D.
Joseph I. Echikson, M.D.
Jerome G. Kaufman, M.D.
Joseph M. Keating, M.D.
Samuel J. Lloyd, M.D.
Arthur W. Lunn
Paul Mecray, Jr., M.D.
Duane E. Minard, Jr.
Glennis S. Rickert, M.D.
Royal A. Schaaf, M.D.
Rudolph C. Schretzmann, M.D.
James H. Spencer, M.D.
Edward W. Sprague, M.D.
John S. Thompson
Thomas J. White, M.D.
Carl K. Withers
Jesse McCall, M.D., 1960-61 President of The Medical Society of New Jersey

Adopted [split vote] (page 434)

(Supplemental Report)

BLUE CROSS AND BLUE SHIELD RIDERS FOR DIAGNOSTIC SERVICES

(Reference Committee "C")

For the purpose of reviewing and discussing the current status of existing and proposed riders for diagnostic services under Blue Cross and Blue Shield contracts, and to obtain direction from the House of Delegates as to the position of The Medical Society of New Jersey concerning such riders, a special meeting of the House of Delegates was held in Trenton on Sunday, March 13, 1960. Seventy-three point nine per cent of the accredited members of the House (1959) list registered and attended the meeting.

The actions of the House were as follows:

1. A motion for the issuance of a joint rider by Blue Cross and Blue Shield was defeated by a large majority vote.
2. The President was authorized to appoint a committee to wait upon the Commissioner of Banking and Insurance for the purpose of opposing the issuance of a separate Blue Cross rider for diagnostic services; and the committee was empowered to study the question with Blue Shield and Blue Cross.

At the request of Blue Shield, Blue Cross agreed to take no steps for the realization of a separate rider until all alternatives could be investigated, with a time limit of April 15, 1960. The Permanent Committee on Blue Cross and Blue Shield Plans met on April 12, and, following considerable discussion it was decided that the only means of resolving the matter satisfactorily to all parties concerned would be for Blue Shield to discontinue its rider for diagnostic services, and for Blue Cross to abandon its intention to issue a separate rider. By mutual agreement of all present—representatives of Blue Cross, Blue Shield, Hospital Association, and Medical Society—the proposal was offered for the consideration of the Boards of Trustees of the four organizations.

The Board of Trustees of the Medical Society unanimously approved the recommended solution and urged that the Board of Trustees of Medical-Surgical Plan concur in that approval.

By majority vote of the Board of Trustees of Medical-Surgical Plan, the sale of Rider A (diagnostic services, x-ray therapy, radioactive isotopes therapy, and radium therapy) was suspended pending further study.

The Board of Trustees of the Hospital Association approved the proposal, and recommended to the General Assembly that it confirm this action. The General Assembly, at the annual meeting of the Hospital Association on April 27, 1960, confirmed the action of its Board of Trustees.

The Board of Trustees of Hospital Service Plan discussed the proposal at its annual meeting, but due to a full agenda no formal action was taken; the matter was postponed for further study.

RECOMMENDATION

The Board of Trustees recommends to the House of Delegates that it approve the proposal that Medical-Surgical Plan of New Jersey agree to discontinue the issuance of diagnostic riders provided that Hospital Service Plan of New Jersey will also agree to make no effort to achieve the issuance of a diagnostic rider under Blue Cross coverage.

Rejected [split vote, 90 to 166] Reference Committee recommendation—that study be continued by the Hospital Association and the Medical So-

ciety to evolve a method for payment by Blue Shield for diagnostic x-ray and diagnostic pathology done in the outpatient department of the hospital at the direction of the attending physician—Adopted (page 434)

(Supplemental Report)

MSA BOARD OF GOVERNORS—NOMINATIONS

(Reference Committee "C")

The following nominations for membership on the Board of Governors of Medical Service Administration of New Jersey for 1960-61 were approved by the Board of Trustees of The Medical Society of New Jersey and are referred to the House of Delegates for action:

Irving P. Borsher, M.D.
Harry N. Comando, M.D.
Arthur W. Lunn
Royal A. Schaaf, M.D.
Rudolph C. Schretzmann, M.D.
Edward W. Sprague, M.D.
John S. Thompson
Thomas J. White, M.D.

Adopted (page 435)

(Supplemental Report)

SCHOOL EXAMINATION LAW—AMENDMENT

(Reference Committee "E")

Senate Bill 147 (1959) was introduced by Senator Ridolfi at the request of The Medical Society of New Jersey (in accordance with the action of the 1958 House of Delegates). The provision of the bill was:

> To permit school medical inspectors to accept the report of a physical examination made on a pupil by his treating physician in lieu of the examination required to be made by the school medical examiner or school nurse.

It was not reported out of committee. After its introduction, Senator Ridolfi and other legislators received many letters from members of The Medical Society of New Jersey in opposition to the measure. In line with this, the Council on Legislation agreed that the House of Delegates may have changed its mind in the interval since adopting the resolution requesting the amendatory legislation. The council recommended to the Board of Trustees and the Board approved, that the entire matter be resubmitted to the House of Delegates for directive, in view of the lack of solidarity of support by members of The Medical Society of New Jersey, as reported by Senator Ridolfi.

RECOMMENDATION

That the House of Delegates direct the Board of Trustees and the Council on Legislation in this matter.

Reference Committee recommendation—that the legislation be re-introduced—Adopted (page 438)

Judicial Council

(Reference Committee "A")

DANIEL F. FEATHERSTON, M.D., Chairman, Asbury Park

In its attempt to keep abreast of its calendar, the Judicial Council met regularly each month except for the summer months. Its agendas were always extensive, and its entire membership regularly was present. This has been an intensely active year; the total of complaints shows an increase over the preceding year. The number, therefore, is still on the rise.

From the official files of the Judicial Council, we present the following resume of the operations of the Judicial Council and of county judicial committees for the year now ending April 19, 1960:

By the Judicial Council:

Appeal Hearings Granted	6
Formal Opinions Rendered	6

a) Ethical acceptability of a member-physi-

cian's "association with an osteopathic physician as a medical inspector in the same local school system" and also his position as "medical coordinator"

b) Ethical acceptability of a member-physician's accepting an invitation to address a local osteopathic society on the subject of cardiology

c) Ethical acceptability of member-physicians' administering Krebiozen

d) Ethical acceptability of osteopathic physicians' participating with the Passaic County Medical Society in its polio immunization campaign

e) Ethical acceptability of methods employed by a certain insurance company

f) Clarification of the terms "professional conduct and ethical deportment" as employed by the Judicial Council

(N.B.—For the information of the membership, these six opinions are presented in full as an appendix to this report.)

Formal Opinion Reaffirmed 1

a) Ethical acceptability of utilization by New Jersey physicians of "package plan" services by out-of-state bioanalytical laboratories (Adopted December 14, 1958, and published as an addendum to the 1959 Annual Report of the Judicial Council—cf. July 1959 issue of THE JOURNAL)

By County Judicial Committees:

Complaints Reported as Disposed of 99

a)	Alleged excessive fees	68
b)	Alleged dissatisfaction with treatment	16
c)	Alleged breach of ethics	3
d)	Alleged negligence	5
e)	Miscellaneous	7

Complaints still pending 9

a)	Alleged excessive fees	7
b)	Alleged dissatisfaction with treatment	1
c)	Alleged breach of ethics	1

Analysis of the types of complaints presented against our member-physicians reflects a marked increase in the number of those alleging "excessive fees." In these fretful economic times, this is an area of growing sensitivity and concern. The members of the public are being encouraged in a highly critical attitude toward medical charges, oftentimes attributing to the physician responsibility for total medical costs—including hospital costs—over which he has no direct control. However, it behooves all of us to be on guard against a tendency too lightly to set charges for professional services. Whatever the charge for professional services, it should admit of complete and clear justification. Very probably we shall continue to be exposed to complaints of this type because of the attitude of the public, but such complaints will be easier to deal with if all our members are painstaking in arriving at the fees that they assign for services which they supply. If we adopt a Relative Value Index, it is likely that our position will be even more improved. It is still wise and desirable for every physician freely and willingly to discuss his fees with his patients. In many instances, his doing so will eliminate the misunderstandings that so frequently culminate in formal complaints.

Questions concerning the permitted professional association of members of The Medical Society of New Jersey with osteopathic physicians continue to be submitted regularly to the Judicial Council. In an effort once and for all to deal with these inquiries, the Board of Trustees of The Medical Society of New Jersey officially concurred in the Council's opinion that "under the principles of medical ethics all voluntary professional association of members of The Medical Society of New Jersey with osteopathic physicians is unethical." At the direction of the Board of Trustees, the Executive Officer reviewed the entire osteopathic problem and published a digest in the August, 1959, issue of the *Membership News Letter*, including references to previously published opinions, stressing that the opinion of the Judicial Council applies to *all* members of The Medical Society of New Jersey regardless of specialty. Copies of this article are available upon request to the Executive Officer. The Council recommends that in future any member who desires information in this regard consult his file of newsletters or obtain a copy of the August 1959 *Membership News Letter* for his information and guidance. The opinions therein cited are the opinions that govern and obtain.

The successful operation of the judicial mechanism—and we are happy and proud to report that it is operating successfully—is due to the splendid cooperation of all who have part in its functioning. To the Judicial Councilors for their unstinting, generous, and faithful service; to the chairmen and members of county judicial committees; to our legal counsel; to our Executive Officer; and to all the assisting staff, I am happy to acknowledge a real debt of gratitude.

ETHICAL ACCEPTABILITY OF A MEMBER-PHYSICIAN'S "ASSOCIATION WITH AN OSTEOPATHIC PHYSICIAN AS A MEDICAL INSPECTOR IN THE SAME LOCAL SCHOOL SYSTEM" AND ALSO HIS POSITION AS "MEDICAL COORDINATOR"

(Opinion adopted September 30, 1959)

In a letter to the Judicial Council, a member presented these facts:

> I have been school physician in this Borough since opening my office here in 1947. Examination of school children was conducted biennially. The school system has grown. An osteopath practicing in town repeatedly applied for position as Medical Examiner. Recently he acquired enough adherents on the Board of Education so that they voted to institute annual examinations, and "since that would make too heavy a burden for one doctor, and to divide fairly the opportunity" they appointed the osteopathic physician as a second Medical Examiner. I requested that the area of responsibility be divided precisely, which was done; except that it was stipulated that I be "coordinator" of medical affairs.

In considering this matter, the Council cited the following opinions issued by the Judicial Council of the Amercian Medical Association:

> 1) Only the House of Delegates can alter policy and until the House is convinced that osteopathy is no longer a sectarian practice and so votes, it is incumbent on the members of the Association to observe existing policy.
>
> The ethical proscriptions against voluntary associations with cultists must be construed strictly. *When such an association is required by law or regulation of the state it can in no sense be considered voluntary and, therefore, is not unethical.* (1955 *Report*)
>
> 2) The Principles of Medical Ethics proscribe voluntary professional associations between doctors of medicine and cultists. *Associations that are required by law or are occasioned by judicial appointment, made in the public interest, cannot be considered to be voluntary and thus are not in contravention of the Principles.* (*JAMA, March* 30, 1957)

The Judicial Council was of the opinion that this member—in his position of "medical examiner"—does not violate the Principles of Ethics, in view of the opinions quoted.

However, the Council was of the further opinion that this member's position as "coordinator" of medical affairs involves a voluntary acceptance on the part of this member of responsibility for the professional performance of the work of an osteopathic physician. In this role, this member would have to accept the osteopathic physician as a professional co-equal. This—the Judicial Council declared—would in its opinion be unethical.

The Judicial Council agreed that if a particular situation transgresses obviously in the area of voluntary professional association, a member-physician in good standing cannot accept it.

ETHICAL ACCEPTABILITY OF A MEMBER-PHYSICIAN'S ACCEPTING AN INVITATION TO ADDRESS A LOCAL OSTEOPATHIC SOCIETY ON THE SUBJECT OF CARDIOLOGY

(Opinion adopted September 30, 1959)

Under date of February 16, 1959—in answer to a request from a member-physician for clearance from The Medical Society of New Jersey to accept an invitation to give a talk on backache before a meeting of the New Jersey Osteopathic Society—the Judicial Council of The Medical Society of New Jersey issued the following opinion:

> It is the opinion of the Judicial Council of The Medical Society of New Jersey that it would be unethical for you to do so.
>
> The Judicial Council of the American Medical Association has issued this statement concerning "Lecturing to Osteopathic Association" (JAMA, March 30, 1957):
>
> The Principles of Medical Ethics proscribe all voluntary professional associations between doctors of medicine and sectarian or cult practitioners. The giving of a medical paper by a doctor of medicine before a group of osteopathic physicians by invitation would be voluntary professional association contrary to the Principles of Medical Ethics.

In this opinion, The Judicial Council of The Medical Society of New Jersey concurs.

Recently the Judicial Council of The Medical Society of New Jersey issued a statement explanatory of the meaning of the term "voluntary professional association." It was published for the information of our members in the January, 1959 issue of the *Membership News Letter*. A marked copy of this issue is enclosed for your attention.

The Judicial Council also calls attention to the fact that this opinion—as are all opinions issued by the Judicial Council—was published as an addendum to the 1959 annual report of the Judicial Council and appeared in the July issue of THE JOURNAL of The Medical Society of New Jersey.

ETHICAL ACCEPTABILITY OF MEMBER-PHYSICIANS' ADMINISTERING KREBIOZEN

(Opinion adopted September 30, 1959)

Members of the Bergen County Medical Society have requested an opinion as to "whether or not it is considered unethical for them to administer Krebiozen to selected patients, even though they recognize that it is to date considered 'a secret drug without value'."

The Judicial Council unanimously agreed that it would not attempt to pass upon the ethical acceptability of physicians' administering Krebiozen to selected patients, because it considered that involved in this question is not so much a matter of ethics as a matter of intelligent professional judgment.

The Council calls attention to the following excerpts from the complete special report on Krebiozen contained in the March 9 issue of the A.M.A. *News*:

> In October 1951, the AMA issued "A Status Report on Krebiozen" which stated that a study of 100 cases showed the drug had no beneficial effects in the treatment of cancer. The cases had come from six cancer clinics.
>
> Following the status report, similar unfavorable reports on Krebiozen were presented by the Committee on Cancer Diagnosis and Therapy of the National Research Council and the University of Illinois' Cole Committee.
>
> The AMA has not seen impartial scientific evidence to refute these findings and maintains its position that Krebiozen is useless.
>
> Furthermore, the AMA regards Krebiozen as a secret remedy because the composition and nature of the drug has not been reported in the traditional scientific manner.
>
> Throughout the controversy, the AMA has neither encouraged nor discouraged clinical studies with the drug. It has, however, been guided by two major responsibilities:
>
> To protect the public and cancer sufferers from improper claims and quack remedies.
>
> To see that recognized scientific methods are used to determine whether or not a drug is of any value in the treatment of a certain disease. Application was made to the Food and Drug Administration for a license to manufacture and sell Krebiozen in 1954. Application was returned with the advice that the drug is a horse serum and should be considered by the Biologic Division, Public Health Service. No application has been made to the PHS agency, which requires proof of therapeutic value.
>
> Contrary to what the pro-Krebiozen group claims, the AMA cannot prevent a physician from purchasing or using the alleged drug.

ETHICAL ACCEPTABILITY OF OSTEOPATHIC PHYSICIANS' PARTICIPATING WITH THE PASSAIC COUNTY MEDICAL SOCIETY IN ITS POLIO IMMUNIZATION CAMPAIGN

(Opinion adopted September 30, 1959)

At the request of the Board of Trustees, the Judicial Council considered a letter of inquiry from the President of the Passaic County Medical Society. The Executive Secretary of the New Jersey Association of Osteopathic Physicians and Surgeons has requested that— if, next year, the Passaic County Polio Chapter and the Passaic County Medical Society establishes "Dollar Clinics" for immunization against polio—osteopathic physicians of Passaic County have a part in this program. The Passaic County Medical Society has requested "advice concerning the proper ethics involved in a procedure of this nature."

By way of answer to this request, the Judicial Council points out that, in a release supplied from the office of The Medical Society of New Jersey to the Bergen and Passaic County Medical Societies under date of November 5, 1958, the following was set forth, and to it the Judicial Council subscribes:

> All doctors of medicine in good standing in their county, state, and national medical societies are governed by the Principles of Medical Ethics of the American Medical Association.
>
> Section 3 of those Principles declares: "A physician should practice a method of healing founded on a scientific basis; and he should not voluntarily associate professionally with anyone who violates this principle."
>
> Osteopathy is defined as: "A system of medical practice based on the theory that disease is due chiefly to mechanical derangement in tissues, placing emphasis on restoration of structural integrity by manipulation of the parts . . ."
>
> This theory is not supported by scientific evidence. As late as 1955, in connection with an inquiry made by the House of Delegates of the American Medical Association, the American Association of Osteopaths was reported as adhering to this unscientific concept which is commonly referred to as "the osteopathic concept."

Therefore, because doctors of osteopathy are practicing a system that is not based upon scientific evidence, all members of the medical profession in good standing in their county, state, and national associations are prohibited from voluntarily associating with them.

However, in the interest of making available to the public the services of all fully li-

censed physicians of the state, it might be advisable—as the Executive Secretary of the New Jersey Association of Osteopathic Physicians and Surgeons suggests—for the osteopathic physicians to set up their own separate clinics, which would be operated solely by osteopaths and in which the doctors of medicine could not associate.

ETHICAL ACCEPTABILITY OF METHODS EMPLOYED BY A CERTAIN INSURANCE COMPANY

(Opinion adopted January 10, 1960)

At the request of the Essex County Medical Society—which called the matter to its attention—the Judicial Council considered a proposed new insurance for expectant parents and malformed babies.

The Judicial Council called attention to the fact that, under this insurance, physicians are being called upon to serve as agents for the insurance company, and are being offered a fee for all who sign up as a result of their urging (i.e. "Each application received at our offices bearing your (doctor's) name in the above manner will be recorded for payment of 'medical services' of $2.50. On the following first day of the month a check will be sent to you for the total number of patients you have assisted and rendered service in connection with their . . . applications.")

The Judicial Council unanimously recorded itself as opposed to participation in any such or similar plan by physicians for a fee, on the basis of its involving unethical conduct.

The Council directed that this opinion be called to the attention of all members of The Medical Society of New Jersey.

CLARIFICATION OF THE TERMS "PROFESSIONAL CONDUCT AND ETHICAL DEPORTMENT" AS EMPLOYED BY THE JUDICIAL COUNCIL

(Opinion adopted January 10, 1960)

In a letter to the Judicial Council, the Secretary of the Bergen County Judicial Committee requested clarification of the terms "professional conduct and ethical deportment" mentioned in a letter issued under date of October 23, 1959, over the signature of the Council Chairman. Reported the secretary: "Your letter . . . leaves the Judicial Committee of this Society confused as to the function of our Committee."

The Judicial Council unanimously agreed upon the following clarification of the terms "ethical deportment" and "professional conduct":

The "ETHICAL DEPORTMENT" of a member-physician is to be judged in terms of his adherence to, and conformity with, the official Principles of Medical Ethics and the interpretations thereof made by the Judicial Council of the American Medical Association and the Judicial Council of The Medical Society of New Jersey.

The adequacy of a member-physician's "PROFESSIONAL CONDUCT" is measurable in terms of two basic considerations:

a) his conformity to the standards of enlightened human conduct proper to, and expected of, a gentleman and a member of a learned profession; and

b) his consistent rendering of professional services of such character as demonstrates that he exercises ability and competence, and utilizes techniques and procedures, such as are typical of and common to the other members of the medical community.

Adopted (page 432)

Executive Officer

(Reference Committee "A")

Richard I. Nevin, Trenton

Just as intelligent navigation inevitably imposes the necessity of compiling an official log, so intelligent organization renders inescapable the compilation and presentation of official reports. Both the log and the reports are instrumentalities by means of which we can appreciate our present position, know how we arrived at it, and within limits foresee the direction in which we are moving.

Administrative years are artificial entities at best. A living organization as vigorous and complex as The Medical Society of New Jersey will not permit of packaging and storage in dead and desiccated bookkeeping units. The flow of the Society's concerns and activities is constant and indivisible. The boundaries of administrative years are, as it were, only the markings along the bank of the coursing stream which is The Medical Society of New Jersey in operation. At times the pace and pulse of this stream are slow, and its volume limited. At other times it roars forward in a turgid and troubled surge, tending toward some resolving climax which will either restore it to tranquility again, or carry it in wild turbulence over a precipice, to dissipate its strength in thundering chaos below.

This is a time of intense and growing activities in the life of our Society. On every side there has been an increase in individuals and agencies, in programs and proposals, that impinge upon, and frequently flagrantly invade, the proper sphere of medical interest and concern. Elemental forces are loose with which Medicine and its practitioners must come effectively to grips if freedom, dignity, and fundamental rights are to be preserved. In the effort to meet and cope with these forces throughout the year, we have all been busily engaged.

I pay tribute to your President, Dr. Clyde Bowers, for the exemplary way in which he has sacrificed his time and energies to serve his colleagues and the public, and for the wholesome vigor of his efforts and accomplishments.

He has not labored alone. The officers and members of the board have in their spheres of action been equally generous and energetic. And the chairmen, and council and committee members have shared in the same attitudes of dedication and action.

Look where you will—to the Society's unequivocal forthrightness of opposition to unwholesome legislation at state and national levels; to the painstakingly detailed efforts of our representatives to be an effective part of the programs connected with both the recent White House Conference on Youth and the approaching White House Conference on Aging; to the work of our liaison committees; to the dependably efficient operation of our judicial mechanism—everywhere you will recognize that good work has been done for Medicine and the people by your worthy representatives.

The activities of the staff of the Executive Offices necessarily increase in scope and tempo with the pace of the Society's operations. This year our outgoing mail alone reached a volume of 245,000 pieces, and more than 25,000 pieces of incoming mail were received and dealt with. This—over and beyond the transcription of minutes, the preparation of reports, rosters, and accounts which are part of our routine responsibility.

My diary reminds me that as Executive Officer, in addition to routine work at desk and writing board, I have taken part—in our headquarters or throughout the state—in 188 meetings and conferences with groups or individuals, have made five protracted trips out of the state, and have delivered a total of thirty speeches.

These are not simple times. Nor do they offer simple problems. The problems which most starkly beset us are not limited to aspects of Medicine or of medical practice alone. We are living in a period of widespread, shortsighted selfishness in all areas of life and living, which if not checked and countered will result in changes tantamount to revolution. As a people, in our blinded and frantic drive to get the most, we may discover that we have forever lost the best . . . unless men and women of true vision and sound judgment by heroic measures prevail.

Not only are freedom and justice for Medicine imperiled in these dark times, but freedom and justice for all. No cause has ever been more worthy or more pressing than the cause in which we have been and are engaged. Our record for the year closing is good, but let us face the new year with the cry, "The best is yet to be!"

Adopted (page 432)

Annual Meeting

(Reference Committee "G")

JEROME G. KAUFMAN, M.D., Chairman, Newark

With the cooperation of the President, the Section Officers, and the Chairmen of the Scientific Exhibits and Scientific Program Committees, an excellent program has been arranged for the 1960 annual meeting. Many diversified subjects are scheduled for the section meetings and the exhibits. We believe the program will have wide appeal among the membership.

The exhibits—educational, scientific, and technical—total 127 this year, a new high for our annual meeting. Despite the fact that we are accommodating more than ever before, we were over-subscribed and could not accept all applications received because of lack of space.

It came to our attention that some of the New Jersey specialty societies were publicizing the annual meeting programs of the sections of The Medical Society of New Jersey as the "annual spring meeting of the New Jersey (specialty group) in conjunction with the (specialty) section of the State Medical Society." This was extremely disturbing and not a little annoying to the Committee on Anual Meeting and the section officers to find that our section programs were being claimed by some specialty groups, even to the point of relegating the sections of the Medical Society to second place. A communication was sent, accordingly, to all New Jersey specialty societies directing their attention to the following, from the rules and regulations governing sections of The Medical Society of New Jersey:

> No specialty group in New Jersey is in any manner connected with The Medical Society of New Jersey except inasmuch as physicians may be members of both groups. The section programs of the Annual Meeting of The Medical Society of New Jersey are arranged by and for our members, and all publicity in connection with the annual meeting program is handled by the Council on Public Relations.

In accordance with the recommendation of the 1959 House of Delegates, the exhibits will open on Sunday, May 15, 1960, to afford the delegates an opportunity to visit the exhibits "since many leave on Monday after the House has adjourned." This early opening will be continued if in the opinion of the committee the results are worthwhile.

The committee cannot emphasize too strongly the necessity for all members to visit the exhibits. The technical exhibitors pay the costs of the Annual Meeting; in appreciation the members should visit the displays and discuss the companies' products with their representatives. The scientific exhibits will present the results of the latest significant investigations; they are worthy of the attention of every member. The educational exhibits present the latest developments in programs and projects of cooperating agencies.

Through the cooperation of Smith Kline and French Laboratories, an interesting motion picture program has been arranged. Appreciation is again expressed to the company for this valuable addition to our annual meeting program.

Because of the increasingly heavy convention schedule each spring in Atlantic City, it has been found advisable to set meeting dates at least four years in advance in order to secure desirable dates and hotel accommodations. The House of Delegates has already approved the following convention dates which have been confirmed with Haddon Hall:

195th meeting—Saturday-Wednesday, May 13-17, 1961
196th meeting—Saturday-Wednesday, May 12-16, 1962
197th meeting—Saturday-Wednesday, May 11-15, 1963

RECOMMENDATION

That the 198th annual meeting be held at Haddon Hall, Atlantic City—Saturday-Wednesday, May 16-20, 1964.

Adopted with re-emphasis on underlined words (page 440)

Scientific Exhibits

(Reference Committee "G")

THOMAS K. RATHMELL, M.D., Chairman, Trenton

Two meetings of the committee were held. At the first meeting in September, 1959, plans for the 1960 Scientific Exhibit were organized. Application forms, rules and regulations, and the list of invitees were reviewed. Last year, objection was raised to exhibits on the Lobby floor. The committee requested that the Vernon Room be assigned this year. This request was granted.

At its second meeting, the committee reviewed the applications received, and booth space was assigned. The committee attempted to group the exhibits in accordance with the subject covered. However, in consequence of cancellations and substitute exhibits, the final grouping will be somewhat disarranged.

Following the date of the last meeting of the committee, several additional applications were received. The details of these exhibits were submitted to the committee by mail, and it was the unanimous opinion of the members that all of the exhibits should be accepted and shown, if additional space could be alloted. Through the courtesy of the Health Insurance Council, which originally had been assigned the Garden Room for its exhibit and coffee lounge, a portion of the Garden Room was assigned to the Committee on Scientific Exhibits, thus enabling us to accept all of the new applications for space. We hereby express our gratitude to the Health Insurance Council for its generous cooperation. Despite this, there are other excellent exhibits which the committee had to turn down for the lack of further additional space.

An award committee has been appointed and arrangements have been completed for the presentation of award plaques and certificates of merit during the course of the annual meeting.

The term of office of your chairman expires with this annual meeting. I notified the President-Elect, Dr. McCall, of my desire to relinquish the office and recommended the appointment of Dr. Milton Ackerman, of Atlantic City, to succeed me. Dr. Ackerman has been a faithful member of the committee for a number of years and is completely familiar with the detailed work of the committee. Dr. Ackerman has been appointed and has accepted the chairmanship of the committee for next year.

At this time, I would like to acknowledge the assistance of the members of the committee and of the Convention Manager and her secretary. My work on the committee has been a most gratifying experience.

Adopted (page 440)

Scientific Program

(Reference Committee "G")

EDWARD E. P. SEIDMON, M.D., Chairman, Plainfield

The scientific program for the 1960 Annual Meeting was developed last September at a joint meeting of the committee with the section officers. The Section on Preventive Medicine has been discontinued because of the evident lack of interest of those members in this field shown in their not arranging a program and electing section officers. If later there is renewed interest, the section will be re-established.

The annual meeting is a "medical forum," and all sections have heeded our urging that their programs be made attractive to the general membership. We believe this year that some phase of the scientific program will appeal to each and every member. The section

officers are to be congratulated for the selection of their topics and their speakers.

An outstanding program, such as our sections have prepared for this annual meeting, deserves recognition by the membership. We hope the members will attend the section meetings of their choice.

Adopted with expressed hope that effective ways may be found to encourage and increase attendance at annual meetings (page 440)

Credentials

(Reference Committee "G")

MARCUS H. GREIFINGER, M.D., Chairman, Newark

The Committee on Credentials was established last year by the adoption of the revised Constitution and Bylaws. Its duties are outlined in the Bylaws, Chapter IX, Section 10, as follows:

> (c) The Committee on Credentials shall review and act upon all applications for membership in component societies. It shall report its actions in writing to component societies.
>
> (d) The committee shall provide component societies with official membership application forms, and it shall devise and adopt an official form for reporting and recording its actions.

The committee met early in the administrative year to prepare the official membership application and report forms. Copies of application forms in use by the component societies were obtained and reviewed. The adopted application is a combination of the best features of the forms previously used by the component societies and of additions made by the committee members. These forms required very careful consideration to make certain that they were complete before the final printed copies were made. Consequently, it was not until the beginning of January, 1960, that the committee could begin to carry out its function of reviewing and acting upon all applications for membership in the component societies.

At its meeting in January, 1960, the first applications were presented to the committee for consideration. It became evident that the committee's activities should be divided into two fields: (1) Consideration of applications submitted through the component societies, and (2) decisions on membership questions and problems submitted by the component societies.

The committee has received 141 applications—34 for regular membership, and 107 for associate membership. Of this group, 27 applications for regular membership, and 85 applications for associate membership have been approved. Twenty-nine applications are under consideration.

Study of the applications resulted in the following recommendations regarding their completion:

1. Applications should be typewritten and proper English spelling used.
2. All questions must be answered or checked to show that they weren't overlooked.
3. Effective April 1, 1960, a recent photograph must accompany each application sent to the Trenton office. (Note: This photograph will then be compared with the physician's photograph on file with the State Board of Medical Examiners.)
4. The component society shall check the chronology from the date of medical school graduation to the date of the application. If more than six months are unaccounted for, the component society shall request the applicant to account for the period.

In reply to questions raised by several component societies, the Committee on Credentials rendered decisions as follows:

TRANSFER MEMBERS WITHIN THE STATE

A physician previously elected to active membership in a component society of this State may be elected to active membership in another component society of this State by

transfer, without having his application processed through the State Committee on Credentials.

COURTESY MEMBERS

A. Inasmuch as no privileges accompany courtesy membership, such applicants should not be required to submit applications to the State committee. If, however, at some future time the courtesy member applies for regular membership, he then must complete the necessary application form, to be processed through the State committee.

B. Courtesy membership in one component society and active membership in another component society may be held without conflict with the provision of the Bylaws which states that no physician may be a member of two component societies at the same time.

C. Differences in terminology pertaining to types of membership in the counties lead to misunderstanding. Therefore the committee adopted the following recommendations:

(1) The Committee on Credentials suggests and hereby requests that the component societies incorporate into their constitutions and bylaws uniform terminology for the various membership classifications—Active, Associate, Emeritus, Honorary, Courtesy.

(2) The Committee on Credentials suggests and hereby requests that inactive types of membership—such as county affiliate or courtesy—be extended only to those who would qualify for full membership (i.e., restricted to M.D.s).

JURISDICTION

All component societies are advised to make every effort to conform with the following regulation from this date on, whether they be considering new applications or transfers from another society:

Chapter XI, Section 5

(a) Ordinarily a physician will hold membership in the component society of the county in which he practices. However, with the permission of that component society, he may for reasons of convenience be a member of some other component society.

ASSOCIATE MEMBERS

Advancement from associate to regular membership is not an automatic process. A second application must be completed and cleared through the State Committee.

REINSTATEMENT OF MEMBERSHIP

A. Former regular or associate members whose memberships have lapsed for any reason must submit applications for State Committee approval before they may again be accepted as members.

B. Former members may be reinstated in the capacity in which they served at the time their memberships lapsed.

A.M.A. SERVICE MEMBERSHIP

Unless an applicant holds membership in another medical society, the fact that he is a service member of the A.M.A. does not permit his election to regular membership.

Chapter XI, Section 4(a) of the Bylaws requires:

Except in the case of transferred membership, each component society must require applicants to serve a probationary period of one (1) to two (2) years as associate members.

The routine for processing applications at regular intervals has been established, and all functions of the committee will be efficiently carried out.

Adopted (page 440)

Finance and Budget

(Reference Committee "B")

DAVID B. ALLMAN, M.D., Chairman, Atlantic City

A review of the expenses and accounts to date indicates that the individual accounts are sound and that a favorable balance in the total budget can be anticipated.

JOURNAL

The Publication Committee is commended for its continued excellent financial status. Again, no budget appropriation has been requested for the publication of THE JOURNAL, JOURNAL office expenses, and travel. The Publication Committee will continue to operate on its advertising income.

1960-61 BUDGET

The proposed budget (below) for 1960-61 in the total amount of $204,279, has the approval of the Board of Trustees, and contains revisions made by the Board.

1961 ASSESSMENT

The computation of cash surplus for the close of the current fiscal year is estimated at slightly above $100,000—which sum has been indicated as the desired surplus amount at the beginning of each new fiscal year. The actual 1960-61 budgetary requirement is $32.95 per capita. However, the committee feels that, rather than lower the 1961 assessment and have to request an increase for 1962, the assessment should remain the same—$35 per capita.

AMERICAN MEDICAL EDUCATION FOUNDATION

Last year the House of Delegates approved the recommendation of the Committee on Finance and Budget "that the per capita level of contribution to A.M.E.F. for 1960 be set by the House in addition to, and not as part of, the budgetary assessment, and that both be paid at the same time."

Not only has this method of contribution resulted in maintaining the budget on an equalized basis—which was our primary aim in making such a recommendation—but it has also resulted in a larger contribution to A.M.E.F. —estimated at $30,000 for 1960. Your committee definitely feels this method of contribution should be continued.

RECOMMENDATIONS

1. A.M.E.F.

   That the per capita level of contribution to A.M.E.F. for 1961 be set by the House of Delegates in addition to, and not as part of, the budgetary assessment, and that both be paid at the same time.

Adopted at $5.00 per capita (page 433)

2. 1960-61 Budget

   That the budget for 1960-61 be adopted in the total sum of $204,279.

Adopted (page 433)

3. 1961 Per Capita Assessment

   That the 1961 assessment be adopted at $35 per capita with no provision for a contribution to A.M.E.F.

Adopted (page 433)

PROPOSED BUDGET FOR 1960-61

A-1	Executive Salaries	$ 53,492.00
A-2	Executive Office Salaries	44,781.00
A-3	Executive Office Expenses	2,000.00
A-4	Executive Travel	2,340.00
A-5	House Maintenance	14,335.00
A-6	Treasurer	3,130.00
A-7	Committee on Finance and Budget	100.00
A-8	Secretary	1,260.00
A-9	Salary Taxes	2,476.00
A-10	Insurance	2,682.00
B	Journal Publication and Office Expenses	(Operates on Income from Advertising)
C-2	Council on Legislation	7,500.00
C-3	Council on Public Health	1,700.00
C-4	Council on Public Relations	10,000.00
C-5	Council on Medical Services	1,100.00

D-1	President and Presidential Officers	10,710.00
D-2	AMA Delegates	4,320.00
D-3	Advisory Committee to Woman's Auxiliary	8,603.00
D-4	Committee on Medical Education	100.00
D-5	Conference Groups	1,000.00
D-6	Directory—Membership and Credentials—Physicians Placement	3,750.00
D-7	Committee on Disaster Medical Services	100.00
D-9	Archives-History	100.00
D-10	Blood Bank Commission	250.00
D-11	Committee on Medical Defense and Insurance	750.00
E-1	Board of Trustees	5,500.00
E-2	Contingent	10,000.00
E-3	Judicial Council	900.00
E-4	Legal	6,300.00
E-6	Committee on Medical Student Loan Fund	5,000.00
	TOTAL	$204,279.00

Adopted (page 433)

Honorary Membership

(Reference Committee "G")

ALDRICH C. CROWE, M.D., Chairman, Ocean City

No names have been submitted for Honorary Membership in The Medical Society of New Jersey. Therefore, it has not been necessary for the committee to meet this year.

No action (page 441)

Medical Defense and Insurance

(Reference Committee "D")

BENJAMIN F. SLOBODIEN, M.D., Chairman, Perth Amboy

At its several meetings this year, the committee has conferred with representatives of the carriers, agents, and brokers concerning the several insurance programs of the Society; complaints from members were investigated; and one accident and health claim was arbitrated.

ACCIDENT AND HEALTH INSURANCE AND LIFE INSURANCE

Your committee is very happy to report continuing expansions in these fields of insurance benefits for members of the Society. In 1958, the Society added an additional plan of accident and health insurance of $400 monthly benefit in the Nationwide Mutual Insurance Company, which, together with the $600 per month available under the first plan of accident and health insurance in the National Casualty Company, makes it possible for eligible members to obtain up to $1000 per month of disability insurance in State Society endorsed plans.

Last year approval was given to a five year renewable and convertible term life policy to be available to all members in active practice and under the age of 65. $10,000 policies were to be issued promptly to acceptable risks without examination, and when 30 per cent of the members applied during the enrollment period

$10,000 policies were to be issued to the impaired risks who were in active practice and under the age of 65. After the initial issue of a $10,000 policy to the acceptable risk, additional units of $10,000 up to $40,000 were to be made available under this plan at the same rates, subject to physical examination.

After an intensive enrollment period conducted throughout the State by the Blanksteen Agency, the 30 per cent quota was achieved on November 25, 1959, thus successfully completing the enrollment. Many life policies were issued not only to good risks but to the impaired risks as well.

Already one death claim has been paid to the family of an impaired risk who was not normally insurable and whose policy would never have been issued if this plan had not been in operation. We understand that as this goes to press, there are three more death claims being processed by the agency.

Approximately 1750 of the members of the State Society have subscribed to this life insurance program and a goodly number of them have applied for excess coverage in amounts of $20,000, $30,000, $35,000 and $40,000, 27 members bought coverage to the full limit of $50,000. We are proud of this accomplishment in making another important insurance protection available to our members. Another advantage of the program is that new members will have the privilege of subscribing for a $10,000 life policy if they apply within four months of the date of their election to membership, irrespective of their medical history, provided they are engaged in the full active practice of their profession and are under the age of 65.

MAJOR MEDICAL INSURANCE

We are now pleased to present still another important insurance project, that of major medical, or as it is sometimes called, "Catastrophic" insurance—a plan that supplements Blue Cross and Blue Shield. Many of the county medical societies in the metropolitan area of New York have been studying this subject so as to provide their members with a plan of insurance that will help meet the costs of an unexpected catastrophic disability to themselves, their wives, or their children. Your committee has approved a Professional Major Medical Expense Policy for the members of our Society.

The major medical policy will provide a maximum benefit of $10,000 for each member of the family for any one accident or sickness with a $500 deductible feature; all expenses above $500 will be divided between the insurance carrier and the policyholder on an 80/20 co-insurance basis—the insurance company paying 80 per cent of all bills over $500 and the policyholder 20 per cent. This plan covers service in and out of hospital but will not include physicians' and surgeons' fees. Our accident and health insurance brokers, E. & W. Blanksteen and their affiliate, E. & W. Blanksteen Agency, Inc., have spent the last three or four years in developing this program in consequence of their recognition of a rising demand for this type of insurance among professional societies. In fact, they have had a pilot plan in successful operation with the New Jersey State Dental Society on a group basis since September 1957.

RECOMMENDATION

That the services of E. & W. Blanksteen be continued as the Society's official broker for its accident and health insurance plan, and for its life insurance plan.

Adopted (page 436)

PROFESSIONAL LIABILITY INSURANCE

Despite repeated requests for information on the Society's professional liability plan, neither the carrier, U. S. F. & G., nor its agent, Faulhaber & Heard, has supplied the necessary data for the preparation of this portion of the committee's annual report. We are hopeful that the necessary information will be made available to us for the preparation and submission of a supplemental report to the House of Delegates.

(Supplemental Report)

MAJOR MEDICAL (CATASTROPHIC) INSURANCE

The Board of Trustees has endorsed the proposed program (as outlined in the committee's annual report) for the consideration of the 1960 House of Delegates.

RECOMMENDATIONS

1. That Plan III for major medical (catastrophic) insurance for members, offered by the National Casualty Company through E. &

W. Blanksteen, be adopted by the House of Delegates.

Disapproved; returned to committee for further study (page 436)

2. That E. & W. Blanksteen be designated as the Society's official broker for this major medical (catastrophic) insurance program.

Disapproved without prejudice until #1 is resolved (page 436)

PROFESSIONAL LIABILITY INSURANCE

On April 27, 1960, the committee met with representatives of U.S.F. & G. Despite repeated requests for data, on which to base this portion of the committee's annual report, such information has not been received. The committee was informed that it is not possible for local offices of U.S.F. & G. to keep us informed of future policies of the company, and that local offices find it difficult to develop a comprehensive picture for the state as a whole. This is due to an internal rearrangement of U.S.F. & G. with its agents and brokers.

The committee was also informed that U.S.F. & G. will no longer accept new applicants for malpractice insurance as of June 1, 1960.

Faulhaber & Heard plan to place professional liability insurance with companies other than U.S.F. & G., but no immediate steps have yet been taken.

The committee recommended to the Board of Trustees that it take cognizance of the existence of this serious and dangerous situation and urged that the Board take immediate, forceful, and constructive action.

Annually it has been the recommendation of this committee, and the House of Delegates has concurred, that Faulhaber & Heard be continued as the official agent of the Society for professional liability insurance. In view of the evident lack of cooperation and existing circumstances the committee recommended to the Board of Trustees, and the Board approved, that Faulhaber & Heard not again be designated as the Society's official agent for professional liability insurance.

Adopted (page 436)

Medical Education

(Reference Committee "D")

SHERMAN GARRISON, JR., M.D., Chairman, Bridgeton

The Committee on Medical Education participated in a Career Program sponsored by Rutgers University in Newark. An exhibit on education in medicine and allied fields was organized by Dr. Morris Saffron and staffed on October 14 and 15, 1959, by members of the committee.

A catalogue library of 16 millimeter films has been set up in the Headquarters of The Medical Society of New Jersey.

The Committee on Medical Education continues to recognize the excellent programs organized by Seton Hall College of Medicine and Rutgers University and their contributions to medical education throughout the state.

The committee wishes to call attention to the comprehensive listing of medical programs in the bulletin "What Goes On" compiled by the Academy of Medicine of New Jersey and The Medical Society of the State of New York, and urges the sponsors of all programs in this state to avail themselves of this opportunity for state-wide announcements.

The committee is available, on request, to assist any group in the organization of programs or the provision of speakers.

Adopted (page 436)

Medical Student Loan Fund

(Reference Committee "B")

Luke A. Mulligan, M.D., Chairman, Leonia

Since its inception three years ago, the Medical Student Loan Fund has granted loans to 20 New Jersey medical students. As of the date of this report we have 4 new applications in process; and we anticipate that 3 students who received loans this year will apply for assistance next year.

The gross fund totals $51,020.18—$34,344.-83, general fund; $5,107.00, Albert B. Kump Memorial Grant; and $16,675.35, outstanding loans. The present amount available for loans in 1960-61 is $6,869.00. We anticipate, however, that contributions between now and June 1, 1960, will increase this amount to $7,-500-$8,000.00.

The goal of the committee is to bring the fund up to $100,000.00, and to that end the committee again urges wide and continuing publicity of the Medical Student Loan Fund to the membership. It appeals for contributions, either to the general fund or as specific memorial grants. We reiterate the recommendation of the reference committee last year, which was adopted by the 1959 House of Delegates, "that all members of the Society think of this Fund as a philanthropy to which they judiciously contribute."

The committee is grateful to the many contributors to the fund and takes this occasion to acknowledge their generous support. A list of contributors to date (4/12/60) since the last report follows:

Albert Barker Kump Memorial Grant—Dr. Nicholas A. Bertha, Cumberland County Woman's Auxiliary, and the State Society in memory of Dr. Charles E. Rosen.

General Fund—State Auxiliary Fellowettes; County Auxiliaries: Atlantic, Bergen, Burlington, Camden, Cape May, Essex, Gloucester, Hudson, Hunterdon, Mercer, Middlesex, Passaic, Salem, Somerset, Union, and Warren; Gloucester County Auxiliary in honor of State Auxiliary President and President-Elect, Mrs. Rowohlt and Mrs. Bush; Passaic County Medical Society; and The Medical Society of New Jersey. Memorial contributions: Dr. and Mrs. Robert W. Traganza in memory of son, Robert W.; Mrs. Ruth Reed, and Mr. and Mrs. Joel Reed in memory of Dr. A. V. Ziccardi; Dr. and Mrs. Paul Sparks in memory of Dr. A. V. Ziccardi and Mr. Ethan Reeves; Dr. and Mrs. William E. Dodd in memory of Dr. Abraham Goldstein; Mrs. Robert G. Bloomer in memory of Mrs. Florence Deacon and Mrs. Helen Curtis; Dr. and Mrs. S. S. Ellenson in memory of Mrs. Irene Rose, Mr. Walter Reid, and Dr. Samuel Hausman; Dr. and Mrs. John Perez in memory of Mr. Frank Scaffidi; Dr. and Mrs. Joseph Borrus in memory of a friend; Dr. and Mrs. Floyd D. Gindhart in memory of Dr. Jacob Belfer; Mrs. Morris S. Joelson in memory of husband, Dr. Morris S. Joelson; Dr. and Mrs. Theodore Graham in memory of Mr. Roy Yates and Mr. Alphous Krantz; Dr. and Mrs. Joseph Rube in memory of Mr. Roy Yates and Mr. Henry Balfour; Dr. and Mrs. Charles L. Brown in memory of Dr. Charles M. Berry; Dr. and Mrs. Jack Swartz, Dr. and Mrs. Albert Markel, Dr. and Mrs. Bernard F. Alpren, Dr. and Mrs. Louis Landau, Dr. and Mrs. John Scillieri, and Dr. and Mrs. Samuel Deich in memory of Mr. Roy Yates; State Auxiliary in memory of Mrs. George A. Corio and Mrs. George A. Rogers; Bergen Auxiliary in memory of Dr. Roe and Dr. Walter J. Farr; Burlington Auxiliary in memory of Dr. A. V. Ziccardi; Camden Auxiliary in memory of Mr. Herman Wiant; Hudson Auxiliary in memory of Dr. Edwin Machowsky; Mercer Auxiliary in memory of Dr. Jacob J. Belfer; Middlesex Auxiliary in memory of friends; Passaic Auxiliary in memory of Mr. Richard Stinson and Mr. Roy Yates; Cape May County Medical Society in memory of Dr. Julius Way; Hudson County Medical Society in memory of Dr. Gene Luongo; and The Medical Society of New Jersey in memory of Dr. Samuel A. Cosgrove, Mrs. Mary Nevin, and Mr. Joseph Stern.

Adopted (page 433)

Publication

(Reference Committee "B")

FRED B. ROGERS, M.D., Chairman, Trenton

In 1959, as in 1958, Dr. Davidson's editorials continued to draw nationwide attention. Of the 35 editorials we published in 1959, no less than eleven were reprinted in other medical journals, or in a few cases, in the lay press. The editorial *Man Behind the Medicines* was not only reprinted, but 60,000 copies were distributed by a pharmaceutical company. The whimsical editorial *If Engineers were Plastic Surgeons* (our July 1959 issue) was quoted in a nationally syndicated column, was reprinted in the *New Physician*, by an out-of-state county medical bulletin, and by several independent newspapers. As a matter of fact, many items in our JOURNAL in addition to Dr. Davidson's editorials were abstracted or quoted in other publications. Nineteen of our JOURNAL's original articles were thus cited in the twelve months of 1959.

A comparison between 1958 and 1959 material in THE JOURNAL is presented.

We are proud of the expansion of our book review department—which last year covered 23 pages, compared with 19 the previous year. Publishers have shown an eager interest in our reviews—even the unfavorable ones—and our JOURNAL is acquiring a reputation in medical-literary circles for the quality of i s book reviews.

	Pages	
	1958	1959
Original Scientific Articles	291	389
Historical Articles	41	13
State Activities	240	238
Editorials	32	30
Marginalia of Medicine	2	3
Civil Defense Items	0	2
Announcements and Letters	17	18
Woman's Auxiliary Material	1	1
County Society Reports	29	31
Book Reviews	19	23
Text Material, Total Pages	672	748
Advertising and Inserts	1084	1162
Grand Total (Pages)	1756	1910

We have also been able to expand our "original scientific articles" section from 291 to 389 pages—an important increase since this is the heart of any medical journal. A 10 per cent rise in our advertising is also noteworthy, and financially gratifying.

For the fifth consecutive year, the committee makes no request for funds for publication of THE JOURNAL. We expect to operate the periodical on our excess of advertising income over publication costs.

Adopted (page 433)

Advisory to Woman's Auxiliary

(Reference Committee "G")

LEWIS C. FRITTS, M.D., Chairman, Somerville

In carrying out our work with the Woman's Auxiliary, we of the Advisory Committee have been following a pattern which has evolved progressively in the last three or four years and which has been proving productive of very satisfactory results.

This pattern is based upon the early submission by the officers of the Auxiliary of the official programs and projects for the year and their early clearance through the Society's Board of Trustees. This procedure makes possible the initiation of approved activities on the part of the Auxiliary by the end of summer, and it does much to facilitate and expedite the year's accomplishments.

It is the function of the Advisory Committee, as set forth in the Bylaws of the Medical Society, "to evaluate, coordinate, and guide

the Woman's Auxiliary in all its interests and activities, subject to the approval of the Board of Trustees of The Medical Society of New Jersey." This function has been carried out successfully this year, with satisfaction that is shared by both the Medical Society and the Woman's Auxiliary. More and more we have been made to appreciate the valuable services —especially in the areas of public relations and legislation—which the Auxiliary so ably and willingly supplies.

I know that I express the sentiments of all the officers and members of the Society when I say that we are deeply grateful to the members of our Woman's Auxiliary for their contributions to the maintenance of professional prestige and to the worth of the services rendered by medicine to the general community. Especially I commend the Auxiliary's President—Mrs. George O. Rowohlt—the other officers, and the chairmen of the many committees, for the willing spirit of understanding and cooperation which has characterized all their efforts throughout the year.

Adopted (page 441)

Proposed Amendments to the Constitution

(Reference Committee on Constitution and Bylaws)

The following proposed amendments to the Constitution were approved by the House of Delegates at the 1959 Annual Meeting, recognizing that such amendments must be considered by the House of Delegates for final vote in 1960. In compliance with the Constitutional provision regarding amendments, the proposals were sent to each component society and published in THE JOURNAL in January 1960.

Current

ARTICLE IV—ORGANIZATION OF THE SOCIETY

Section 2 — Fellows

The Fellows are the Past-Presidents of this Society.

Any member of this Society, not already a Fellow, who is elected President of the American Medical Association, shall at the completion of his term, become a Fellow of this Society.

Section 4 — Delegates

(a) *Apportionment and Election.* Each component society shall be entitled to one (1) delegate for each fifteen (15) members or major fraction thereof, to be elected at any meeting prior to March 31 of the fiscal year by a majority ballot of the members present. Each delegate shall be elected for three (3) years. Each component society shall be entitled to at least three (3) delegates.

Proposed

ARTICLE IV—ORGANIZATION OF THE SOCIETY

Section 2 — Fellows

Add the following footnote:

(The "immediate past-president" is that living past-president between whom and the presidency no succeeding living past-president intervenes.)

Adopted (page 441)

Section 4 — Delegates

(a) *Apportionment and Election.* Each component society shall be entitled to one (1) delegate for each fifteen (15) members or major fraction thereof, to be elected at any meeting prior to March 31 by a majority ballot of the members present. The term of office of each delegate shall be for three (3) administrative years and shall begin on April first next following his election. Each component society shall be entitled to at least three (3) delegates.

Adopted (page 442)

ARTICLE IX—OFFICERS

Section 2 — Election

The Officers shall be elected by ballot at the second session of the House of Delegates at the annual meeting. No member shall be eligible for more than one (1) office at the same time, except the President, the President-Elect, the First and Second Vice-Presidents, the Secretary, and the Treasurer, who by virtue of such offices are at the same time members of the Board of Trustees. A vacancy in office occurring between annual meetings may be filled by the Board of Trustees until the next regular election.

ARTICLE IX—OFFICERS

Section 2 — Election

The Officers shall be elected by ballot at the second session of the House of Delegates at the annual meeting. No member shall be eligible for more than one (1) office at the same time, except the President, the President-Elect, the First and Second Vice-Presidents, the Secretary, and the Treasurer, who by virtue of such offices are at the same time members of the Board of Trustees. A vacancy in office, except that of President-Elect, occurring between annual meetings may be filled by the Board of Trustees until the next regular election.

Adopted (page 442)

ARTICLE XII—AMENDMENTS TO THE CONSTITUTION

A. *Procedure for First Year*

1. Submission of the proposed amendment in writing, through the Secretary of this Society, to the Standing Committee on Revision of Constitution and Bylaws and to each component society by the Board of Trustees, the Judicial Council, or a component society, at least three (3) months before the annual meeting.

ARTICLE XII—AMENDMENTS TO THE CONSTITUTION

A. *Procedure for First Year*

1. Submission in writing of an amendment proposed by the Board of Trustees, by the Judicial Council, or by a component society to the Secretary of this Society not later than February first.

2. Transmission by the Secretary of the proposed amendment to the Standing Committee on Revision of Constitution and Bylaws and to each component society not later than February 15.

(Renumber balance—paragraph 2 becomes 3, etc., ending with paragraph 10 becoming 11.)

Adopted (page 442)

Proposed Amendments to the Constitution and Bylaws

(Reference Committee on Constitution and Bylaws)

From the Union County Medical Society

CONSTITUTION

ARTICLE VI—BOARD OF TRUSTEES

Current

The Board of Trustees shall be the executive body, and shall be composed of the Immediate Past-President, President, President-Elect, two (2) Vice-Presidents, Secretary, and Treasurer (by virtue of their offices), and eleven (11) members—at least two (2) from each judicial district, and who shall each be elected for a term of three (3) years, such term to commence upon expiration of the term of the then incumbent.

Proposed

(Underlined words are amendments)

Section 1—Composition

The Board of Trustees shall be the executive body. It shall be composed of the Immediate Past President, President, President-Elect, two (2) Vice-Presidents, Secretary, and Treasurer (by virtue of their offices), and elected Trustees. Each County shall be entitled to at least one (1) Trustee and for the larger counties they shall be entitled to one (1) Trustee for each five hundred (500) active or voting members or fraction thereof as of December 31 of each year. Each Trustee shall be elected from and by his component county society prior to the annual meeting of the House of Delegates. The term of office shall be three (3) years and such term shall commence upon the expiration of the term of the former incumbent. The term of office of one third (1/3) of the elected Trustees shall terminate annually.

Section 2—Procedure

Provided that at the first election following the adoption of these amendments, the first seven (7) counties alphabetically, from Atlantic through Essex, shall elect one Trustee from each county for one year, the second seven (7) counties, from Gloucester through Morris, shall elect one (1) Trustee from each county for two (2) years, and the third seven (7) counties, from Ocean through Warren, shall elect one Trustee from each county for three years. Counties with more than one (1) Trustee shall elect them on a staggered basis, for one (1), two (2), and three (3) years. Thereafter at the expiration of these terms each Trustee shall be elected for a full term of three (3) years.

Section 3—Term of Office

From and after May 21, 1953, any member may be elected a Trustee for a maximum of three (3) full terms, provided, however, that if the first two (2) elected terms are successive, there shall be a lapse of one (1) year between expiration of the second and commencement of the third term. The term of any Trustees commencing prior to May 21, 1953, shall not be included in the limitation of three (3) elected terms.

Any member as classified in Article VI, Section 1, may be elected a Trustee for a maximum of three (3) full terms provided however that if the first two (2) elected terms are successive there shall be a lapse of at least one (1) year between expiration of the second (2) and commencement of the third (3) term.

Section 4—Filling Vacancies

In the event that the office of any member becomes vacant for any reason the component county society wherein the vacancy exists shall elect a member within ninety (90) days to fill the unexpired term.

At the first election of Officers following the adoption of this Constitution, three (3) members shall be elected for a period of one (1) year; four (4) members for a period of two (2) years; four (4) members for a period of three (3) years; and, as the terms of these elected Trustees expire, new elections shall be for periods of three (3) years each.

(DELETE entire paragraph)

For action on these proposals, see report of Revisions Committee (page 393)

BYLAWS

Proposed for Voting in 1961

Current | **Proposed**

CHAPTER V—PROCEDURE OF ELECTION

Section 1—Nominating Committee

(d) The delegates, or their alternates, so elected from their respective component societies and the representative of the Fellows shall compose the Nominating Committee. This committee shall meet in the evening of the first day of the annual meeting and report the results of its deliberations to the House of Delegates in the form of nominations for each of the offices to be filled, including Trustees, elected members of com-

(d) The delegates, or their alternates, so elected from their respective component societies, and the representative of the Fellows shall compose the Nominating Committee. This committee shall meet in the evening of the first day of the annual meeting and report the results of its deliberations to the House of Delegates in the form of nominations for each of the offices to be filled, elected members of committees, Councilors, Delegates and Al-

mittees, Councilors, Delegates and Alternate Delegates to the American Medical Association, and Delegates and Alternate Delegates to other medical organizations.

ternate Delegates to the American Medical Association, and Delegates and Alternate Delegates to other medical organizations but excluding Trustees.

No action (page 443)

CHAPTER VI—RIGHTS AND DUTIES OF OFFICERS

Section 5—Board of Trustees

(a) Organization. At the first meeting of the Board of Trustees following each annual meeting of the House of Delegates, the Board of Trustees shall organize by electing a chairman and a secretary. The chairman shall name the membership of all committees of the Board of Trustees. Meetings shall be called by the chairman, but any four (4) Trustees may—in writing and for stated reason—require the chairman to call a meeting. Notices of meetings shall be mailed at least seven (7) days in advance of the meeting date. Nine (9) Trustees shall constitute a quorum.

(a) Organization. At the first meeting of the Board of Trustees following each annual meeting of the House of Delegates, the Board of Trustees shall organize by electing a chairman and a secretary. The chairman shall name the membership of all committees of the Board of Trustees. Meetings shall be called by the chairman, but any four (4) Trustees may—in writing and for stated reason—require the chairman to call a meeting. Notices of meetings shall be mailed at least seven (7) days in advance of the meeting date. Eighteen (18) Trustees shall constitute a quorum.

No action (page 443)

Revision of Constitution and Bylaws

(Reference Committee on Constitution and Bylaws)

Louis F. Albright, M.D., Chairman, Spring Lake

The committee reviewed proposed amendments to the Constitution submitted by the Union County Medical Society for consideration of the 1960 House of Delegates. Mercer County Medical Society had also approved the proposals.

Primary objective of the proposed amendments is to have representation from each component society on the Board of Trustees. In this instance the committee did not feel justified in taking a position on the proposals —either favorable or in opposition—but only to study them. But we point out the following which should be carefully studied by the reference committee and the House:

1. Currently the Board of Trustees is composed of 18 members whose reported attendance is almost consistently 100 per cent at all meetings.
2. The Board now meets regularly the third Sunday of each month for an average of 6 to 7 hours each meeting.
3. The proposed amendments would result in a 34-member Board. Consideration must be given to the difficulty of finding men who would attend meetings that frequently and serve that diligently; otherwise, it will result in a disservice to the membership, component societies, and the Society as a whole, and thus weaken the functions of the Board of Trustees.

The committee is of the opinion that the proposed amendments should be considered and acted upon in two steps:

Step 1—Should the composition of the Board of Trustees be changed?

If the answer is "no," then there is no need to consider the proposed amendments.

If the answer is "yes," then the proposed amendments must be dealt with, and should involve the following determinations:

Step 2.—Possible bases of representation on the Board of Trustees (as of current membership)

a. One elected Trustee from each component society (total 21)

b. One elected Trustee from each component society on basis of 500 members or fraction thereof (total 27)

c. One elected Trustee from each component society on basis of 500 members or major fraction thereof (total 23)

d. One elected Trustee from each component society on basis of 1000 members or fraction thereof (total 22)

e. One elected Trustee from each component society on basis of 1000 members or major fraction thereof (total 21)

The committee points out that the simple assignment of one elected Trustee from each component society would make the structure of the Board less complicated than a system embracing proration. The committee also felt that one elected Trustee from each component society would be in keeping with the structure of the State and Federal government since the House of Delegates is based on proration.

****

The following changes in the proposed amendments are considered necessary by the committee:

[Words in brackets are deletions from the proposed amendments as submitted by the Union County Medical Society]

Underlined words are changes considered necessary by the committee

Constitution—Article VI—Board of Trustees

SECTION 1—COMPOSITION

The Board of Trustees shall be the executive body. It shall be composed of the Immediate Past-President, President, President-Elect, two (2) Vice-Presidents, Secretary, and Treasurer (by virtue of their offices), and elected Trustees. Step. 1. Each [County] component society shall be entitled to [at least] one (1) elected Trustee. [and for the] Step 2. The larger [counties they] component societies shall be entitled to one (1) elected Trustee for each five hundred (500) [active or voting] members or fraction thereof as of December 31 of each year. [Each] Trustees shall be elected from and by [his] component [county society] societies prior to the proper annual meeting of the House of Delegates. The term of office shall be three (3) years (subject to the maintenance of membership totals under proration) and such term shall commence upon the expiration of the term of the [former] incumbent. The [term] tenure of office of approximately one-third (1/3) of the elected Trustees shall terminate annually.

Committee note: If proration is not adopted, the phrase in parentheses (subject to the maintenance of membership totals under proration) and the word "approximately" can be deleted.

Defeated [split vote, 82 to 106] (page 443)

SECTION 2—PROCEDURE

Committee note: Delete the entire section as proposed inasmuch as there must not be a complete break-up of the Board—incumbent Trustees are entitled to complete the terms for which they were elected, and there must be continuity of direction of the Society through the Board of Trustees.

Substitute the following:

Following the adoption of these amendments incumbent Trustees shall serve out their elected terms as representatives of the component societies in which they hold membership. Remaining and succeeding Trustees shall be elected by component societies the year following the adoption of these amendments for one (1), two (2), or three (3) year terms—to equalize the process.

Out by defeat of Section 1

SECTION 3—TERM OF OFFICE

Any member [as classified in Article VI, Section 1,] may be elected a Trustee for a maximum of three (3) full terms.

Committee note: Delete the balance of the section.

It is the opinion of the committee that a lapse of a year between the second and third terms in office is undesirable. If there is to be a limitation of duration of service, it should not restrict a Board member to less than three terms. It takes a new Trustee most of his first term to become

acquainted with the Society's business and to become able efficiently to fulfill his duties. The possibility of his being returned to office after a lapse of only one year is practically nil; and if he is returned after a lapse of three years he has lost contact with the business of the Society and is no better qualified than a completely new Trustee would be. The committee feels that if a man is a good Trustee he should continue uninterruptedly for the three terms, and if he is a poor Trustee he should be replaced.

Approved for final consideration in 1961 (page 444)

SECTION 4—FILLING VACANCIES

In the event that the office of any [member] elected Trustee becomes vacant [for any reason] the component [county] society wherein the vacancy [exists] occurs shall elect a [member] successor within ninety (90) days, to fill the unexpired term.

Out by defeat of Section 1

****

Bylaws—Chapter V—Procedure of Election
Section 1—Nominating Committee

Chapter VI—Rights and Duties of Officers
Section 5—Board of Trustees

The proposed amendments to these sections of the Bylaws, also from the Union County Medical Society, were noted. However, inasmuch as their adoption is contingent upon the adoption of the proposed amendments to Article VI of the Constitution and cannot be considered and acted upon until the 1961 annual meeting, the committee will not report on these proposals at this time.

No action (page 443)

****

BERGEN COUNTY RESOLUTION re REDUCTION OF HOUSE OF REPRESENTATIVES

The committee reviewed this resolution which Bergen County has submitted to the House for consideration. However, inasmuch as it must be adopted by the House before proper amendments can be drafted, no action was taken.

****

VACANCIES IN THE HOUSE OF DELEGATES

(Reference Committee "A")

The Committee on Revision of Constitution and Bylaws reviewed the report of the Secretary to the Board of Trustees concerning the 73 delegates who did not attend the majority of sessions of the House at the 1959 annual and 1960 special meetings, together with the recommendations for determining vacancies. This report and recommendations were approved by the Board.

The committee approved the procedure adopted for the determination of vacancies as a necessary implementation of the relevant section of the Constitution (Article IV, Section 4). The committee directed that its action be called to the attention of the proper reference committee.

Adopted (page 432)

ADMINISTRATIVE COUNCILS

Legislation

(Reference Committee "E")

C. Byron Blaisdell, M.D., Chairman, Asbury Park

Organized and operating for the first year under the newly revised constitutional provisions, this Council has again reviewed state and national legislation. It has screened bills for their inherent good, bad, or indifferent effects upon the health of New Jersey citizens and the health services provided for them, as well as to discover and oppose any legislative trends toward the so-called "welfare state."

The Council has also reviewed referrals from the Board of Trustees, reporting as indicated, or framing and introducing legisla-

tion as directed. In this latter area, there have been bills related to (1) control of hypnosis for clinical and educational use only, and (2) examination of school children in a physician's office in lieu of examination by a school physician. This second bill failed to get favorable action and was not passed last year, possibly because of a difference of opinion evident within our own membership which was voiced to the legislature. Another bill, recommending annual registration of physicians, will probably come up for consideration in the 1960 House of Delegates. It will be remembered that this was introduced previously in 1957 at the direction of the House of Delegates, but it never got out of committee.

STATE LEGISLATION

Two factors have contributed to reduce the necessity for deliberative activity in this field. One is the recurrent and therefore familiar control of bills introduced about which our Society's position is well established. Examples would be bills aimed at reducing drunken driving; presumption that some chronic degenerative disease-disabilities found in policemen, firemen, and other public servants are the result of employment; licensing of physiotherapists, and so forth.

Much interest and discussion developed about the administration of intravenous solutions by nurses, with the nurses, Board of Medical Examiners, the Attorney General, ourselves, officers, and counsel all participating. A resolution of differences has been reached, as the President's report indicates, and nurses with special qualifications will hereafter be free to give specified solutions intravenously at the direction of the licensed physician in charge.

A second factor contributing this year to lessen legislative activity at state level has been a combination of two long recesses of the legislature and, possibly, some diversion of interest by the legislators to the national election year.

Nonetheless, as of the middle of March we were turbulently involved, in consequence of the introduction of Assembly Bill 556—by Mssrs. D'Aloia, McGowan, and Wilson. This piece of legislation—inspired and supported by the Administration—would invest the Commissioner of Banking and Insurance with the power to set the fees to be paid to physicians rendering professional services under the Medical-Surgical Plan.

As soon as copies of the bill were available, the Medical-Surgical Plan of New Jersey and The Medical Society of New Jersey made strong statements of opposition to the Governor, the state legislators, and the press, pointing out that the measure is in violation of the basic right of professional free enterprise and in flagrant disregard of the best interests of the two million citizens of New Jersey who are subscribers to the Plan.

The fight has not—at the time of this writing—been brought to issue. The members of The Medical Society of New Jersey, the members of the Woman's Auxiliary, and all fair-minded and right-thinking citizens are called upon to bring pressure to bear upon senators and assemblymen alike to defeat this pernicious and destructive piece of legislation.

Annoyingly, while we were beating the drums of opposition to A-556—and our experience has shown that it is advisable to deal with only one important measure at a time—A-177—the bill to license physical therapists—silently slid out of assembly committee and was passed by the Assembly by a vote of 40 to 7. Our next step, therefore, is to achieve effective opposition to the measure in the Senate. We are opposing this act to grant separate licensure to the physiotherapists because we are convinced that physiotherapists are adequately recognized and properly regulated under the Medical Practice Act in its present form. In this the State Board of Medical Examiners agrees. If the physiotherapists are to remain—as in the interest of the public they should remain—under the direction and control of licensed physicians there is no need for a separate licensing act. We know that achievement of a separate licensing act has all too frequently been the prelude to a subsequent declaration of independence.

NATIONAL LEGISLATION

Major interest has been centered on H.R. 4700, the Forand Bill, which would provide—for those over 65 and on Social Security—hospitalization, emergency surgery and nursing services, regardless of need, financed by increased taxation and by-passing the states in payments. In resisting this type of legislation and in accord with the American Medical Association, our Society and the Woman's Auxiliary have responded vigorously, voicing by letters, telegrams, personal visits, and alliances with other organizations our determined opposition.

An excellent statement of our opposition to H.R. 4700 and our desire to maintain a

government free from unnecessary centralization and socialistic growth was read into testimony before the House Ways and Means Committee last July. It was submitted by President Bowers who, with Mr. Nevin, has led and stimulated the Society's activity. Your Council can take little credit for this or the other widsepread activities.

At present (April 7), thanks to President Eisenhower who flatly rejected the Forand Bill, and to the House Ways and Means Committee, which refused to release it, by a vote of 17-8 the bill lies relatively dormant. If it is to remain so, pending the $2,000,000 study being made for the White House Conference on Aging in January 1961, it behooves us to participate vigorously and with convincing data in conferences planned for New Jersey, aimed to determine the needs of our elderly citizens. Most imminent is one scheduled for May 19th in Glassboro.

You are urged, both by the A.M.A. and the Council which reflects its leadership, to vote and to get others to vote in November for candidates who promise to uphold the way of life and the practice of medicine which represents your own individual thinking. You are not bound by your membership to alter your views one iota but are expected to VOTE in November.

H.R. 10, the Keogh-Simpson or old Jenkins-Keogh Bill, is in a very favorable position in the Senate and may be passed by the time you read this.

A supplementary report will be submitted in May if enough transpires in the next five weeks to indicate its desirability. Excellent coverage has been given to the membership by the *Membership News Letter,* not only as to the entire legislative scene but also to the political philosophy attending the issues. The Council is deeply appreciative of this support and urges the membership to read and re-read these portions of the *Membership News Letter* and translate them into action as the year advances.

Adopted (page 437)

Medical Services

(Reference Committee "E")

IRVING KLOMPUS, M.D., Chairman, Bound Brook

Among the matters considered by the Council on Medical Services were the following:

1. 1959 House of Delegates resolution concerning entertainment hypnosis—joint conferences with the Special Committee on Mental Health, the outcome of which was a joint recommendation that legislation be prepared and supported to prohibit entertainment hypnosis in New Jersey.

2. Investigation into a complaint concerning non-participating anesthesiologists under Medical-Surgical Plan. The results of the investigation revealed that there were no grounds for the complaint.

3. The main project of the council was to complete its work on a Relative Value Index for New Jersey. The council members gave generously of their time and we feel completion of this project is a definite forward step. The Board of Trustees has reviewed the Index and approved it in principle. We trust that the following resume of our activities will be explanatory to the House of Delegates. The proposed Relative Value Index for New Jersey will be made available to the members of the House in a separate publication.

NEW JERSEY RELATIVE VALUE INDEX

During the past two years, the Committee on Medical Practice, and during the current year, the Council on Medical Services has been studying the concept of a Relative Value Index. The study was originally undertaken because of inequities in Blue Shield payments, and continued after 1958 when the AMA recommended that each state make such a study. In making this recommendation, the AMA was of the opinion that the need was apparent in the light of current developments and that unless medicine undertook this activity, it might be done by others who were less qualified. The Board of Trustees of The Medical Society of New Jersey has approved

the principle at all stages of the study, and has recently approved in principle both the proposed Preamble and Relative Value Index and their consideration by the House of Delegates in Atlantic City in May.

A Relative Value Index (R.V.I.) is not a fee schedule. It is the compilation of a list of procedures and the establishment of an equitable relationship between one and another of these procedures. In determining the R.V.I. an arbitrary value, not in dollars, is assigned to each procedure. These relative values have been set not by outsiders but by our physicians themselves. As an example, suppose an office visit were assigned the value of one unit, then an outside visit might be rated at one and a half units; or again, if a tonsillectomy-adenoidectomy were 15 units, an appendectomy might be 30 units.

How are these relative values arrived at? Fortunately, California pioneered in this field. They have had a R.V.I. since 1956. Their valuations were determined at considerable expense by questioning physicians concerning the usual charges for procedures and then, by elaborate actuarial methods, deriving the basic ratios or relationships between and among procedures. Although the values of the various procedures were reported to the actuaries in dollars, only the arithmetical relationship between the values of the various services was desired. Further, the procedures have been divided into four categories—Medical, Surgical, Pathological, and X-Ray. Because of obvious basic differences, it is the feeling that there should be no cross-valuations among these major divisions. However, it is assumed that the relationship between the value of an appendectomy and that of a T & A, for example, would be the same whether it were done on the east or west coast, or for that matter, in Timbuktu. The dollar value, however, is another matter. This is the individual doctor's own problem and he must determine it for himself. However, it is to be hoped that his fees will be fair, justifiable, and consistent. Most doctors today are not in favor of "Robin Hood" medicine; i.e., the type that robs the rich to give to the poor.

Using California's R.V.I. as a guide, our committee had meetings with the liaison members of all twenty-one of the specialty and sub-specialty groups in New Jersey. R.V.I. was explained in considerable detail, nomenclature and suggested evaluations were discussed. The representatives, in turn, took this information back to their societies and changed the values to conform with their experienced judgment and practice. In other words, we have not imposed these relative values upon anyone. They have, in all cases, come from the doctors most intimately concerned with them. This, we feel, is truly unique about the R.V.I. It is a valuation set up by those in a position to know best the relative ease or difficulty of a given procedure under ordinary circumstances.

The R.V.I. has several specific uses, first, in the negotiation of dollar schedules; second, in adjusting inequities in insurance payments; third, as a guide to young practitioners; fourth, as a basis for judgment by local medical societies in disputes concerning fees.

First, there are several fee schedules which are now operating in New Jersey, such as those in Medical Plans, Blue Shield, State Workmen's Compensation, etc. There has never been any specific body of values set up by the Medical Society to negotiate these schedules, and each of these schedules has been individual. In some cases, pre-existing schedules have been used or imposed upon us. Our R.V.I. gives us a means of testing the reasonableness of any proposed scheme of payment for medical services and will be most important in making changes. All doctors are aware of the slow acceptance of proposed changes in valuation of services.

Second, many private insurers sell indemnity insurance which has inequitable payments. For example, the fee for common procedures, such as a normal delivery, appendectomy, T & A may be inadequate; but fees for rare procedures may be disproportionately large, in order to make the policy saleable. With the R.V.I., doctors will be able to point out to the purchaser and the vendor of this insurance the inequities that occur, and to suggest what the medical profession considers fair ratios.

Third, new doctors, beginning practice, are sometimes puzzled as to fair charges. The R.V.I. would give them an appraisal of fair values. The same applies to an older man who may have to undertake some procedure which he rarely performs.

Fourth, none of us has sympathy with the medical fee gouger! Unfortunately, there are some around and their actions reflect only discredit on the majority of physicians. The R.V.I. will help a county judicial committee or the state judicial council in handling these problems. Another, less serious, but nevertheless, annoying medical economic problem is the "loss leader doctor." This man charges a ridiculously low office fee in order to attract large numbers of people so that he can perform out-

rageously expensive surgical or medical procedures on them. This is "good business" in the business world, but is hardly in the best tradition of medicine. The R.V.I. would help keep this man's fees fair because no judicial committee, in case of complaint, could help him support a surgical fee inconsistent with his usual charges.

The R.V.I. purposely makes no distinction between specialists and non-specialists. Each doctor decides what his basic unit value is worth, depending on the area in which he lives, whether it is urban, rural, high-cost, high-rent, etc. The R.V.I. will not tell anyone what to charge. It will only help the physician or surgeon to safeguard the fairness of his charges.

The R.V.I. is an additional aid to doctors in extending their services to all in a fair and equitable manner. It originated from the labor of doctors and is based upon their knowledge and judgment. No one can argue with the fact that there have been social changes in the methods of paying for medical care, advances or regressions, as you may decide for yourself, and that these changes, as far as can be determined are indicative of a growing trend. Doctors must live with third party payment for medical services and a Relative Value Index is, in our judgment, the best means available for assuring fairness to all.

R.V.I. referred to component societies for study and determination of the wishes of their members; the results of the foregoing to be reported to the Board of Trustees by November 1, 1960; and the Board shall present the results to the next meeting of the House of Delegates, annual or special (page 437)

Public Health

(Reference Committee "F")

Robert S. Garber, M.D., Chairman, Belle Mead

The Council on Public Health was enlarged to include eight special committees this year under the Medical Society reorganization plan. Generally speaking, most of the members of the council and the chairmen of the special committees have responded by working faithfully towards the acquisition of a continued good program on public health for New Jersey. On the other hand, some members were exceedingly lackadaisical in their attitudes as indicated by repeated absences at all or most of the meetings which were scheduled a year in advance. Most of the special committees worked very diligently and kept the council informed of their activities, with the exception of one which, although it met, presented no reports. As a result of these few instances, it would appear that definite changes should be made in the membership of this council as well as in the special committees.

Time schedules are very important. We selected our meeting dates sufficiently in advance and notified all special committees so that they would have ample time to meet, prepare their reports, and forward them to the council for action, hopeful that there would be ample opportunities to prepare information for action by the Board of Trustees at its regularly scheduled meetings. However, this has not occurred in many instances. We are presuming that all members of the Society are exceedingly busy. Nevertheless, it is hopefully desirable that when information is requested, or committees are requested to meet and report their accomplishments in ample time, that such would be made available as promptly as possible. If any chairman can devise a more effective means that one can utilize in effectively maintaining a two-way communication system, all of us would be profoundly grateful for specific suggestions.

The council appointed from its membership liaison members to serve as "reminders" to the special committees. It was their specific assignment regularly to prod a chairman of a special committee into activity so that we could then gain benefit from such reports. This was a fairly successful procedure but not en-

tirely so, and every effort will be made toward its improvement.

SPECIAL COMMITTEES

Great tribute must be paid to a number of special committees and their very faithful members for a full agenda and many worthwhile accomplishments.

Conservation of Hearing and Speech has completed and gained approval from the Board of Trustees for an "Organization and Procedural Code for Hearing and Speech Centers." We are all exceedingly proud of this piece of work, which was a long time in its making.

Conservation of Vision has been particularly active; has been confronted with a number of delicate problems which it has handled very effectively and forcefully. It again organized an Eye Health Screening Program, similar to the sucessful program conducted last year. It has encouraged the Society's co-sponsorship of an exhibit on eye and ear services to be presented at the November, 1960, meeting of the New Jersey Education Association. It has continued to serve as a watchdog on inroads being made by the para-medical groups and has been alert to pick up any efforts toward legislation on these matters in order to advise our Council on Legislation.

Mental Health has been confronted with enormous problems. These were of such a magnitude that we have requested that the committee be enlarged so that it can be divided into small sub-committees to work on particular assignments. Most noteworthy has been its continued collaboration with the New Jersey Mental Health Commission, an activity which has required participation in several public hearings relative to the remodeling of the Mental Health Act. It continues to study a referral from the Board of Trustees asking for evidence justifying proposed legislation to prohibit entertainment hypnosis. It continues to study a recommendation from the Board of Trustees acknowledging the need for a review of the care of the alcoholic patient and the desirability of coordinating the facilities for such care by placing them in one department of the state government. In addition, problems relating to Medico-Legal psychiatry, mental hospitals, the care of the mentally retarded, narcotic addiction, the establishment of child evaluation centers, sponsoring a direct supply of tranquilizer drugs by community lay organizations, and the treatment of convulsive disorders, are only a few of the many problems of concern to this special committee. Accordingly, it is hoped that this special committee will be enlarged in order to deal more effectively with these problems.

Child Health prepared and sponsored a symposium on "Student Athletic Activities and Prevention of Athletic Injuries," to which representatives of the New Jersey State Department of Health, Parent-Teachers Associations, school coaches, and school physicians were invited.

Chronically Ill and the Aging has been busily occupied in working in preparation for the White House Conference (1961) and in organizing the New Jersey Joint Council to Improve the Health Care of the Aged. The Joint Council membership includes The Medical Society of New Jersey, the New Jersey Hospital Association, the New Jersey State Dental Society, the Licensed Nursing Homes Association of New Jersey, Inc., and the New Jersey State Nurses' Association.

Rehabilitation has been hard at work on preparation of a Directory of Rehabilitation Services—a pilot survey of rehabilitation services in Mercer and Burlington Counties is in progress—and forthcoming is a meeting with county committees on rehabilitation.

Cancer Control has directed its efforts toward having a cancer registry initiated in every hospital in New Jersey and toward establishing a state-wide registry in the near future in cooperation with the Cancer Division of the State Department of Health.

Maternal and Infant Welfare has held two meetings, but no reports of its activities were made available to the council.

It has remained our distinct privilege to continue to have the opportunity of working with many interested members of the council and the diligent special committee chairmen who have worked so faithfully in endeavoring to promote a continued and progressive program of public health services for the members of The Medical Society of New Jersey.

Adopted (page 439)

Public Relations

(Reference Committee "E")

John F. Kustrup, M.D., Chairman, Trenton

The function of the Council on Public Relations as set forth in the Bylaws (Chapter IX, Section 8b) is to evaluate, suggest, and —with approval—carry out programs and projects calculated to further the public relations of this Society; and to report findings and recommendations to the Board of Trustees relative to official policies, positions, and activities of this Society in the field of public relations.

This function the Council has been painstakingly fulfilling. Two full committee meetings were held in the course of the year, and a number of special conferences involving individual members of the Council entrusted with responsibility for particular projects took place.

The following continuing activities were taken care of as basic to the year's public relations projects:

1) The revised edition of Series One of the Society's *Junior Health Hints* was distributed to the teaching personnel of public and parochial high schools throughout the state requesting it. In all, some 2,625 copies were so distributed, to be used as the basis for regular classroom presentations.

2) By the close of this administrative year, ten issues of the *Membership News Letter* will have been produced and mailed to the entire membership.

3) Two issues of the *Periodic Newsletter* have already been issued. Both have been dedicated to the Society's point of view and plan for action concerning the Forand Bill (H.R. 4700). Each issue of the *Periodic Newsletter* was sent to the general membership, the members of the Woman's Auxiliary, all board chairmen and hospitals in New Jersey, and to all cooperating agencies. The total number of copies in the two issues came to 20,000.

In conjunction with the Forand Bill, the Council also assisted in the dissemination of the President's statement as submitted to the House Ways and Means Committee for inclusion in the record of its July 1959 hearings on the Forand Bill.

4) The Council issues fortnightly *Health Hints* to all the daily and weekly newspapers of New Jersey and to numerous house organs who have requested that they be supplied. Twenty-seven issues of separate *Health Hints* were mailed to a total of 385 selected media of dissemination.

5) Apart from its regular releases to papers, the Council from time to time issues *special news releases*. Among those presented this year were special releases dealing with:

(a) 1959 Eye Health Screening Program . . . This was a nine-page compilation supplied in mid-September to all the daily and weekly newspapers and to all the radio stations.

(b) Symposium on Student Athletic Activities, sponsored by the Society in early April of 1960. This two-page release was supplied to 255 daily and weekly newspapers.

(c) President's Statement of Opposition to A-556. A two-page special release, under date of March 27, was supplied to all the daily newspapers.

6) The details concerning the *Golden Merit Award* are dealt with by the Council on Public Relations. This year there are to be thirty-two recipients of the Golden Merit Award. Plaques commemorative of the bestowal will be presented at the 194th Annual Meeting. Publicity will be arranged specifically to cover this presentation honoring the recipients, and as in past years special attention will be asked for on the part of local papers in the areas from which the Golden Merit Award recipients come.

7) The Council will again this year be in charge of all *press coverage* of the Annual Meeting. As in past years, publicity will all be mailed out before the convention. The center of press and publicity activity at the convention will be Room 134 Haddon Hall. The press room is under the supervision of the Administrative Assistant to the Executive Officer, and the direction of its activities is his responsibility. Members of the Council assist in the activities of the press room and are available to help arrange for necessary interviews. Through the press room, information is given to press representatives, interviews are arranged, and publicity pictures are scheduled.

In 1959, our annual meeting was written up—in coverage embracing all its features—in a grand total of 149 newspaper articles, including 12 out of state. Sixteen pictures were published.

SPECIAL ACTIVITIES

(1) *Identifying Membership Decals.* With the approval of the Board of Trustees, the Council made available to all the members, through the component county medical societies, official M.D. membership and associate membership decalcomanias. These are being issued only to members and associate members in good standing. It is hoped that they will serve as an effective means of identifying members and associate members when properly displayed on the automobiles or in the offices of those entitled to use them. The Council has long been of the opinion that some identifying insignia should be supplied to the members of The Medical Society of New Jersey for general purposes of identification, and this opinion has been this year strengthened by the fact that many of our members are no longer using M.D. license plates on their automobiles.

(2) *New Format for News Releases.* To make the official news releases of The Medical Society of New Jersey more appealing and arresting to the weary eyes of editors, this year the Council approved the adoption of a new masthead in two colors for news releases prepared especially for this purpose.

(3) *Representative Speakers.* From time to time the Council upon invitation supplies representative speakers to appear before interested groups. This phase of our activity is one which, in view of the many controversial issues affecting medical interests and activities today, we shall probably enhance in the near future.

It is not possible to enumerate all the individual items that are publicized by the Council. Anyone familiar with the *Membership News Letter* and the *Periodic Newsletter* will realize that they are very diversified and that they run the gamut of demand and interest. The Council strives to supply for the membership and the general public all necessary information concerning matters of moment and programs of importance and interest.

As chairman of the Council I am pleased to report that two issues of the *PR Doctor*—a publication of the Communications Division of the American Medical Association—have contained complimentary comments concerning public relations activities of The Medical Society of New Jersey. In the issue for May 1959 the details of the 1959 Eye Health Screening Program publicity were dealt with in terms of high praise. In the issue for October 1959 our *Membership News Letter* was cited for the originality and effectiveness of its reporting of the official attitudes and views of the then candidates for the United States Senate—The Honorable Harrison A. Williams, Jr. (D) and The Honorable Robert W. Kean (R).

Also as chairman I wish to record my appreciation of the interest and assistance consistently supplied by the members of the Council, and to express the indebtedness of the Council for the dependable services of the Executive Officer and his Administrative Assistant and all the cooperating members of the staff.

Adopted (page 437)

SPECIAL COMMITTEES TO THE ADMINISTRATIVE COUNCIL ON MEDICAL SERVICES

Industrial Health

(Reference Committee "E")

WILLIS B. MITCHELL, M.D., Chairman, Toms River

The Special Committee on Industrial Health went on record as favoring a system of impartial medical testimony. The experience of the states of New York and Illinois in this field was received and forwarded to the Special Committee on Medical-Legal Testimony.

The Special Committee on Industrial Health agreed to:

1. Initiate a state-wide roster of industrial physicians including those who manifest interest in same.
2. Continue a program to stimulate interest in small plant medical coverage.
3. Recommend more active participation of medi al profession at Annual State Industrial Health Conference.
4. Develop closer liaison between the committee and the State Industrial Medical Society.

Adopted (page 437)

Workmen's Compensation

(Reference Committee "E")

JOSEPH A. LEPREE, M.D., Chairman, Elizabeth

Since the committee has not been called upon to study any particular problem by the Board of Trustees, no report is being submitted. However, the chairman is of the opinion that the following two important matters need consideration by the proper committee of the State Society:

1. Adoption of a schedule whereby cardiac disability in compensation cases can be more readily evaluated.

2. Conference with representatives of the Claims Bureau of the State of New Jersey concerning fees in compensation cases involving state employees. It is understood that this matter is already under way through a special committee of the Board of Trustees.

Adopted with recommendation that the special committee conduct the study re evaluation of cardiac disability #1 above (page 437)

SPECIAL COMMITTEES TO THE ADMINISTRATIVE COUNCIL ON PUBLIC HEALTH

Cancer Control

(Reference Committee "F")

JOHN L. OLPP, M.D., Chairman, Englewood

The Special Committee on Cancer Control considered the publication of articles on recent advances in the diagnosis and control of cancer in THE JOURNAL of The Medical Society of New Jersey. The committee recommended to the Council on Public Health that original papers composed by members of the Medical Society be published in THE JOURNAL as in the past, but that reviews, statistical compilations, and abstracts of other papers on cancer be rejected because these articles will duplicate the contents of such publica ions as the Year Book of Cancer.

A study was made of the hospital cancer registry project. Forty cancer registries are said to be functioning in the State of New Jersey which has 92 approved general hospitals. The establishment of a cancer registry in each of the remaining 52 hospitals is not simple and requires the cooperation of the medical staff and record librarian of each hospital.

Of the various registry systems and tentative procedures discussed, one plan proposed a county registry to which all local hospitals and clinics would report; another foresaw the institution of a state cancer registry in the New Jersey State Department of Health, and then the mandatory institution of registries in all of the hospitals licensed by the state. Cancer would be made a reportable disease under another plan, with all physicians reporting to a state registry. Mandatory reporting of disease is said to be only 70 per cent effective.

A uniform record system was considered essential to the success of any cancer registry program. The registry forms of the Medical Case History Bureau, 17 West 60th Street, New York 23, New York, were deemed practical and adequate. The cost of initiating a cancer registry was estimated at $500 to $600 for forms, file cabinets, etc. Many hospitals are said to lack trained personnel in their record departments.

RECOMMENDATION

That further study be made of the establishment of a cancer registry in each hospital, a project in which the New Jersey State Department of Health is also interested.

Adopted; continued study re cancer registries encouraged (page 439)

Child Health

(Reference Committee "F")

ROBERT E. JENNINGS, M.D., Chairman, South Orange

The chairman of this committee, as the official representative of The Medical Society of New Jersey, attended the Seventh National Conference on Physicians and Schools, sponsored by the AMA, held at the Hotel Moraine, Highland Park, Illinois on October 13-15, 1959.

The special committee sponsored a Symposium on Student Athletic Activities and Prevention of Athletic Injuries. This was held at Seton Hall Gymnasium, South Orange, on April 2, 1960. It was attended by representatives of the Physical Education, Administrative, Nursing, Dental, and Medical Departments of New Jersey Schools, as well as parent groups. It is hoped that this will serve as a pattern for similar meetings at county society level, with close association between the coaching staffs and physicians.

The committee reconsidered the question of fluoridation of water for the prevention of dental caries. In the absence of new evidence of deleterious effects of fluoridation in the recommended dosage, the special committee reaffirmed its desire for the adoption of fluoridation.

The chairman of this committee, as liaison officer to the State Department of Education, met with the Director of the office of Health, Safety, and Physical Education concerning the suggested modification of the "Proposed Recommendations for Pupil Examination." Specific recommended changes were made on the question of eye examinations and on emotional and mental health.

The committee agreed to cooperate with the Special Committees on the Conservation of Hearing and Speech and the Conservation of Vision in the preparation of a guide for the detection and direction of preschool children with such problems in these areas.

RECOMMENDATIONS

1. That The Medical Society of New Jersey urge its component societies to foster meetings with local school administrators, physical educators, parents, dentists, and physicians, using the pattern of the Symposium on Student Athletic Activities and Prevention of Athletic Injuries, held at Seton Hall, on April 2, 1960, as a guide.
2. That the Medical Society reaffirm its endorsement of water fluoridation for the prevention of dental caries.

Adopted (page 439)

Chronically Ill and the Aging

(Reference Committee "F")

WILLIAM H. HAHN, M.D., Chairman, Newark

The Special Committee on the Chronically Ill and the Aging reiterates its request for a continuation of efforts to develop county society committees for the care of the chronically ill and the aging. These committees could be effective in studying the needs of the chronically ill and the aging at the local level, and in stimulating the development of any needed facilities. Information and referral centers to provide information on available facilities are an immediate need. The county society is in the best position to afford leadership for these centers, bringing together all agencies interested in the problems of the chronically ill and the aging.

The chief accomplishment of our committee this year was the establishment of the New Jersey Joint Council to Improve the Health Care of the Aged. In this venture The Medical Society of New Jersey was joined by:

The New Jersey State Dental Society
New Jersey Hospital Association
Licensed Nursing Homes Association of New Jersey, Inc.
New Jersey State Nurses' Association

The New Jersey Joint Council has concurred in the recommendation of the Special Committee on the Chronically Ill and the Aging that a meeting be held at state level to consider the health needs of the aged in New Jersey, for the purpose of taking steps to prepare and submit the findings and recommendations to the White House Conference on the Aging, which will be held in January, 1961. The committee feels that this is a matter of special importance, as at the present time it does not appear that there will be dependable representation of accurate medical findings otherwise.

Adopted (page 439)

Conservation of Hearing and Speech

(Reference Committee "F")

S. EUGENE DALTON, M D., Chairman. Ventnor

The Special Committee on Conservation ot Hearing and Speech is happy to report definite progress in the following categories:

The Board of Trustees of The Medical Society of New Jersey approved recommendations of the committee:

1. That all schools of higher learning recognized by the State Department of Education be certified as training centers for audiologists and speech therapists, with particular attention at this time devoted to the State Teachers' Colleges and Rutgers University.

2. That the Children's Seashore House in Atlantic City be accepted by the Society as a center for the conservation of hearing and speech.

3. That the component societies aid in locating pre-school as well as school children having hearing or speech problems.

The Newark Center—Barkhorn Memorial Hearing and Speech Center—has recently taken on the state-supported activity in pathology under their audiologists and speech pathologists in addition to the hearing and speech activities which have been performed there in the past six years. However, there are some things to be desired in regard to the scientific assistants, and for that reason their training program should attain a higher degree of efficiency, such as a Ph.D. in speech and auditory subjects, as a protection for the otologists, laryngologists and other members of the professional specialties.

The Trenton Center—located at the St. Francis Hospital—shows excellent progress in its general expansion and in its testing of preschool and school children. This testing is performed by trained staff personnel.

The re-established Atlantic City Center is showing definite progress. The United States Coast Guard property has now been transferred to the Children's Seashore House with the stipulation that it will house a center for the conservation of hearing and speech.

The committee suggests that all approved hearing and speech centers in the State of New Jersey be encouraged to greater activity. If possible, representation from the centers should be incorporated into the membership of the special committee.

The committee also suggests that greater effort be put forth in stimulating interest in the conservation of hearing and speech—possibly through securing the help of the State Medical Auxiliary and the state affiliated women's clubs.

Adopted (page 439)

Conservation of Vision

(Reference Committee "F")

CHARLES E. JAECKLE, M.D., Chairman, East Orange

This special committee continued its work on eye services for school children and prepared a report "The Referral of School Children for Eye Care," which was approved by the Board of Trustees and published in brochure form. It is being distributed to selected medical and educational personnel. Copies may be obtained on request to the Medical Society at its headquarters. The committee collaborated with the Special Committee on Child Health in advising the New Jersey State Department of Education on standards for referral in school medical inspection services.

On referral from the Board of Trustees, the committee continued its study of the subject of eye services for employed persons on a group funded basis, to develop methods to provide such services by the individual physician in his office on a fee for service basis. A pilot plan which would meet these requirements was submitted to and approved by the Board of Trustees. The activation of such a plan would be on the initiative of eye physicians on a county basis.

The week of September 26—October 1, 1960, has been designated as Eye Health Week. The support of the public and private agencies in a program similar to that of previous years will be invited.

On the recommendation of the committee, the Medical Society will co-sponsor, with the New Jersey Academy of Ophthalmology and Otolaryngology, an exhibit at the annual meeting of the New Jersey Education Association in November 1960.

The committee is engaged in a continuing study of certain aspects of contact lens fitting. The authorized comparative study of the Medical Practice Act and the Optometric Act is also in process.

Adopted with exception of second paragraph concerning Eye Care on a Funded Basis (page 439)

Maternal and Infant Welfare

(Reference Committee "F")

JOHN D. PREECE, M.D., Chairman, Trenton

The major amount of the committee's time, this year, was given to the work of studying and classifying maternal deaths throughout the state.

Earlier this year, we recommended that the New Jersey State Department of Health be requested to resume the routine Rh. typing of all maternity cases. This, the committee feels, is of vital importance.

The Maternity Records' Book, which is dis-

tributed to hospitals by The Medical Society of New Jersey, is also up for revision this year. The committee has revised the old form and included new material which will give additional information on the condition of the infant at birth.

Cooperating with the Maternal and Child Health Division of the Department of Health, the committee has continued its special work of the past two years in evolving and perfecting a new questionnaire for the reporting of maternal and infant data. In this work the committee has become increasingly aware of the legal complications involved.

Adopted (page 439)

Mental Health

(Reference Committee "F")

VINCENT P. MAHONEY, M.D., Chairman, Camden

The Special Committee on Mental Health met three times during the year and submitted three reports to the Council on Public Health.

Following is a list of the activities of the special committee:

1. Joint conference with Council on Medical Services concerning proposed legislation to prohibit the practice of hypnosis for entertainment purposes.
2. Review of the problems of the criminal responsibility of the mentally ill and the mentally deficient. A joint committee has been appointed composed of representatives of the Medical Society, the Neuropsychiatric Association, and the New Jersey State Bar Association.
3. In order to determine the extent of the problem of convulsive disorders in the state and how the problem might be handled, the New Jersey Consultation Service was asked to submit details of a formal plan.
4. The Board of Trustees agreed in principle with the special committee's recommendation that funds be made available for the treatment of alcoholics in general hospitals, and that such funds be a combination of both local and state funds.
5. Conferences are being arranged between the chairman of the special committee and the State Commissioner of Health, and the State Commissioner of Institutions and Agencies to consider additional personnel facilities and budgetary allowances for carrying out a program for the treatment of alcoholics, under the supervision of the Director of Mental Health.
6. In response to a request that the State Society approve the Mental Health Association's underwriting the costs of tranquilizing drugs for a group of mental patients who are (a) discharged from public mental hospitals; or (b) medically indigent, the special committee recommended that the costs of these drugs be underwritten by the New Jersey Association for Mental Health when such drugs are prescribed by a physician and indigency is certified.
7. The special committee will, in the future, deal with a study—recommended by the New Jersey State Commission on Mental Health—regarding the care and legal rights of mental patients in the State of New Jersey. The Commission has been in session for approximately two years, has made many recommendations, and is now requesting opinions on these recommendations from the State Society.

Adopted (page 439)

Rehabilitation

(Reference Committee "F")

Elmer J. Elias, M.D., Chairman, Trenton

At a joint meeting of the Special Committee on Rehabilitation with county chairmen and representatives of the State Department of Health, it was recommended that a questionnaire be sent to each physician in New Jersey inquiring as to the type of work he is doing in reference to rehabilitation. It was also suggested that forms be sent to all New Jersey hospitals asking specifically about their rehabilitation facilities. Through conferences with the State Department of Health, it was finally decided that a pilot survey of physicians and hospitals should be made initially in Mercer and Burlington Counties.

At its spring meeting—for the purpose of evaluating the results of the pilot survey in Mercer and Burlington Counties—it was decided that in spite of the excellent cooperative effort of the reporting physicians the data require considerable classification and revision to be useful in compiling a directory.

The committee believes that funds for the salary and administrative needs of one or two medical social workers should be sought from the Office of Vocational Rehabilitation. However, if funds are not available from this source, then the committee intends to recommend that the project be undertaken by The Medical Society of New Jersey. It is anticipated that the project can be completed within a year.

The committee is also of the opinion that all interested groups should be notified, through proper publicity channels of the State Society, that such a survey of rehabilitation facilities is being undertaken by The Medical Society of New Jersey, and be requested to cooperate in every possible way. Such publicity will prevent duplication of effort.

Adopted (page 439)

SPECIAL COMMITTEES

Disaster Medical Services

(Reference Committee "F")

R. Winfield Betts, M.D., Chairman, Medford

The report of the Special Committee on National Emergency Medical Care of the American Medical Association has been released recently. This report contains sound and pertinent recommendations and is endorsed by our committee. Since these recommendations are now available, our committee feels that this is the time to re-evaluate our State program and to revise our thinking in line with those of experience and stature at national level.

Your committee is distressed by the lack of initiative and by the dearth of leadership demonstrated by the Medical Department of the N. J. State Civil Defense Disaster Control organization, whose direction is by law under the State Commissioner of Health. This phase of medical planning and training for disaster has been treated either as a forlorn medical step-child with purposeful neglect, or has been relegated to the realm of the unimportant because of lack of personnel and/or funds. This attitude is unfair, unhealthy, and unrealistic. The State Commissioner of Health should be petitioned by this Society to provide proper medical leadership and supervision for medical disaster planning.

Members of the special committee have attended several training programs during the past few years and have left these programs discouraged, dejected, and disappointed with the demonstrations. We believe the time has long passed for us to make up our minds whether a program of medical disaster pre-

paredness is or is not important. If it is—le 's do something about it. If it is not—let's stop wasting time and turn all of our efforts toward something more important. The cooperation of the medical profession of this State will not be difficult to obtain when it is demonstrated that there is a realistic program under proper direction. This has not been demonstrated to date.

RECOMMENDATIONS

1. That the State Commissioner of Health be petitioned to obtain new and competent medical leadership in the field of Disaster Medical Care and to provide the medical and allied professions in this State with a proper program for disaster preparedness.

2. That the Executive Department of the State of New Jersey be advised by The Medical Society of New Jersey of this lack of a proper and realistic medical program.

3. That the antiquated New Jersey Plan for Medical Preparedness be revised forthwith in line with present day medical thinking.

4. That a program be inaugurated for training allied medical and paramedical personnel in the principles of disaster medicine and that their services be integrated with those of the medical profession. In any large disaster, whether from natural causes or from enemy action, these services must be utilized. It is unrealistic that those who must render service be not promptly and adequately trained for the role they must of necessity perform.

5. That each hospital in the State be encouraged to formulate a disaster plan and to have an annual trial run of this plan. It is further urged that those hospitals close to county borders integrate their staff assignments with County Medical CD-DC Coordinators and with their County Medical Society in order that conflicting interests be resolved before embarrassment occurs in actual disaster.

6. That the pages of THE JOURNAL of The Medical Society of New Jersey be offered to the State CD-DC organization for publication of items of medical interest. These services have been utilized to a limited extent during the past year. All of the material submitted has been published. It is felt that much of interest and of value has not been submitted.

7. That the services of The Medical Society of New Jersey be offered to the State Commissioner of Health in the implementation of any of the aforementioned recommendations, including our considerable influence with our legislators in obtaining proper budgetary allotments, if lack of such allotments is the "bottleneck" in proper medical programming.

Adopted (page 439)

Traffic Safety

(Reference Committee "F")

A. M. K. MALDEIS, M.D., Chairman, Camden

This has been a year of very limited activity upon the part of the committee because of the change in direction of the Division of Motor Vehicles.

In prior years there have been numerous meetings of the committee and conferences with the Director of the Division of Motor Vehicles of New Jersey.

Many thoughts relative to the physical and medical phases of the operation of motor vehicles were discussed and reported. Any possible assistance by the physicians of New Jersey has been offered to the Division of Motor Vehicles, and acknowledgments of the offers were received. If and when the occasion arises, we feel sure that The Medical Society of New Jersey will respond to the call. In the meantime, unless requested the committee can only convene for the purpose of further discussion of its own ideas. There have been no requests for any action or advice from the acting Director of the Division of Motor Vehicles.

It is the opinion of the chairman that the Special Committee on Traffic Safety should be continued, at least for stand-by reasons.

Adopted; committee urged to push its relations with State Division of Motor Vehicles (page 439)

Physicians Placement Service

(Reference Committee "D")

MARCUS H. GREIFINGER, M.D., Chairman, Newark

The Physicians Placement Service continues to prepare and supply to interested physicians descriptive lists of New Jersey areas suitable for the establishment of a private practice. Lists of physicians desiring to locate in the State are also compiled and distributed to municipal and township authorities who feel their areas require additional practicing physicians. Further use is made of the list of physicians —copies are forwarded to practicing physicians in need of assistants or associates, to industries and to divisions of the State government in search of medical personnel.

Inquiries received during 1959-60 from physicians interested in establishing a practice in New Jersey		296 (100%)
Referred by the A.M.A.	102	
Direct inquiries	194	
	296	

Located in New Jersey	33 (11%)
Located elsewhere	81 (28%)
Dropped from list because of failure to respond to follow-up communications	115 (39%)
On active list as of 4/15/60	67 (22%)

The overall picture of placement activities remains relatively unchanged. The majority of applicants want to specialize and to associate with established specialists; few indicate any interest in general practice. This makes it difficult at times to supply names for immediate vacancies.

Clerical procedures connected with the operation of this service are carried on by members of the executive office staff as part of their regularly assigned duties.

Adopted (page 436)

RESOLUTIONS

1

Representation in House of Delegates

(Reference Committee on Constitution and Bylaws)

From the Bergen County Medical Society

Whereas, a deliberative and legislative body of more than 400 members;

1. constitutes an unwieldy assembly, incapable of proper deliberative procedure,
2. when complicated by roll calls or the like allows too little time for study of the many projects that we are asked to consider,
3. if not restricted promptly will perforce outgrow the facilities available to our assembly,
4. so dilutes the responsibility of the individual as to lessen his interest in rendering effective service, therefore be it

Resolved, that the Constitution and Bylaws of The Medical Society of New Jersey be amended to provide:

1. a reduction in the number of delegates from the several county societies to one for every twenty active members of each society, retaining however the same

minimum representation as presently is provided for the smaller county societies,

2. incorporation within the framework of the revised portion of the Constitution and Bylaws an escalator clause that will obligate the Board of Trustees to lessen the proportional representation each year in such a manner as to limit the number of delegates to four hundred, therefore be it further

Resolved, that this resolution be forwarded to The Medical Society of New Jersey and that it be considered by the 1960 House of Delegates and that an informational copy be sent to each component society in advance of the annual meeting of The Medical Society of New Jersey.

Adopted for referral to and action by Committee on Revision of Constitution and Bylaws (page 444)

2

Interns

(Reference Committee "D")

From the Bergen County Medical Society

Whereas, there has been a continuing shortage of interns in hospitals in the United States (over 2,000 a year), and

Whereas, many hospitals have been unable to secure their full quotas of interns with resultant deterioration of their training programs, therefore be it

Resolved, that the American Medical Association, through its Council on Medical Education, be directed to re-evaluate the approved intern programs so that the available supply may be more equitably spread over all the approved hospitals with more regard to the numbers of patients to be cared for, and to the needs of the hospitals, and their ability to train physicians in the arts of Medical Practice, and be it further

Resolved, that this resolution be forwarded to The Medical Society of New Jersey and that it be considered by the 1960 House of Delegates and that an informational copy be sent to each component society in advance of the annual meeting of The Medical Society of New Jersey.

Adopted (page 436)

3

MSP Apportionment of Fees

(Reference Committee "C")

From the Mercer County Medical Society

Whereas, the members of the Mercer County Medical Society have always disapproved of any form of apportionment of fees, no matter in what terms designated, and

Whereas, the Mercer County Medical Society went on record several years ago, by resolution, disapproving the adoption of any plan by the Medical-Surgical Plan of New

Jersey which permitted the allocation of a portion of the surgeon's fee to another physician, and

Whereas, despite the opposition of the Mercer County Medical Society and its delegates, this plan was adopted by The Medical Society of New Jersey, and following its approval, the Medical-Surgical Plan of New Jersey incorporated item 31, with an explanatory paragraph in its Service Report, and

Whereas, the American College of Surgeons has flatly, definitely, and emphatically disapproved of all forms of apportionment of fees, and

Whereas, the American Medical Association has also disapproved of the apportionment of fees, and

Whereas, the continuation of item 31 and its explanatory paragraph in the Service Report of the Medical-Surgical Plan of New Jersey implies agreement by all participating physicians with its unpleasant connotations, therefore be it

Resolved, that the Mercer County Medical Society go on record as again opposing the apportionment of fees in any form, and be it further

Resolved, that item 31, with explanatory remarks be stricken from the Medical-Surgical Plan of New Jersey's Service Report, and be it further

Resolved, that this resolution be placed before the House of Delegates for appropriate action at the next annual meeting of The Medical Society of New Jersey.

Disapproved (page 435)

4

Social Security for Physicians

(Reference Committee "E")

From the Essex County Medical Society

Whereas, the Essex County Medical Society presented a resolution in favor of social security coverage for physicians at the 1959 meeting of the House of Delegates of The Medical Society of New Jersey, and

Whereas, the House of Delegates approved this resolution, thereby placing The Medical Society of New Jersey officially in the position of supporting the inclusion of physicians under social security coverage, therefore be it

Resolved, that the Essex County Medical Society recommend that The Medical Society of New Jersey send a formal directive to each of the delegates to the American Medical Association from The Medical Society of New Jersey, requesting that he actively support the State Society's official position favoring social security coverage for physicians at the next meeting of the House of Delegates of the AMA.

Adopted [split vote, 146 to 36] (page 438)

5

Interns

(Reference Committee "D")

From the Passaic County Medical Society

Whereas, there has been a continuing shortage of interns in the United States, and

Whereas, many hospitals have been unable to secure their full quotas of interns with resultant deterioration of their training programs and in patient care, therefore be it

Resolved, 1. that the grade for standard certification by the Educational Council for Foreign Medical Graduates be reduced for the present,

2. that the deadline for acceptance be extended, thus giving the hospitals more time for adjustment, and be it further

Resolved, that this resolution be forwarded to The Medical Society of New Jersey and that it be considered by the 1960 House of Delegates, and that an informational copy be sent to each component society in advance of the annual meeting of The Medical Society of New Jersey.

Amended: word "reduced" changed to "re-evaluated;"

Add: "and be it further resolved that this resolution be forwarded to the A.M.A." Adopted as amended (page 437)

6

Major Medical Insurance for Physicians

(Reference Committee "D")

From the Somerset County Medical Society

Be It Resolved, that The Medical Society of New Jersey explore the possibilities of initiating an insurance program to provide major medical coverage for the members of its component medical societies.

Adopted (page 436)

7

MSP Apportionment of Fees

(Reference Committee "C")

From the Hudson County Medical Society

Whereas, on May 4, 1954, the Hudson County Medical Society passed a resolution recommending to the New Jersey Medical-Surgical Plan

a. That in making payment for surgical procedures, the Plan designate the amount as payable for *surgical services,* and not as the *surgeon's fee*;
b. That the Plan pay both the surgeon and the assistant (or the referring doctor,* as the case may be);
c. That if sufficient funds are not available to pay both the surgeon and the assistant (or referring doctor*) *in full,* the Plan divide the payment proportionately between the two; in other words, the Plan compensate in part, both the surgeon and the assistant (or referring doctor*);
d. That the patient be notified by the Plan of the payment being made to the surgeon and to the assistant (or the referring doctor*);

Whereas, this is still considered a fair and ethical handling of the situation; therefore be it

Resolved, that the Hudson County Medical Society reaffirm its position and so inform the New Jersey Medical-Surgical Plan that it wishes the practice of apportionment of surgical fees to be continued, and be it further

Resolved, that a copy of this resolution be sent to each component county society for their approval.

*The physician who has rendered pre-operative or postoperative care is termed the "referring doctor" in this motion.

(Received by Board of Trustees 3/20/60, and referred to 1960 House of Delegates without prejudice)

Adopted (page 435)

8

Eye Care on Funded Basis

(Reference Committee "F")

From the Middlesex and Cumberland County Medical Societies

Whereas, the "pilot" plan on a funded basis for medical eye care, made available to unions by means of a third organization, is opposed by the majority of the ophthalmologists in New Jersey, and

Whereas, the New Jersey Academy of Ophthalmology and Otolaryngology on November 11, 1959, by an overwhelming majority went on record as opposing the "pilot" plan, and reported this feeling to the Board of Trustees of the State Medical Society of New Jersey, and

Whereas, such a "pilot" plan is discriminatory, would place free choice of physicians in jeopardy, and is not in the best interest of the public at large.

Whereas, the Special Committee on the Conservation of Vision was not unanimous in favoring such a plan,

Whereas, the Board of Trustees of The Medical Society of New Jersey, has approved the "pilot" plan for the reason that, "it would work to the benefit of the ophthalmologists," in direct opposition to the wishes of the New

Jersey Academy of Ophthalmology and Otolaryngology who constitute the majority of ophthalmologists in New Jersey, and since this ruling is against the practice and will of the majority of ophthalmologists in New Jersey, therefore be it

Resolved, that we, the Middlesex (Cumberland) County Medical Society, as in the New Jersey Academy of Ophthalmology and Otolaryngology, are opposed to the "pilot" plan on a funded basis for medical eye care by means of a third organization; and that the Board of Trustees of The Medical Society of New Jersey rescind its approval of the "pilot" plan; and that this resolution be forwarded to the House of Delegates at the 1960 Annual Meeting for action.

(Received by Board of Trustees 3/20/60, and referred to 1960 House of Delegates without prejudice)

No action (page 440)

9

Aeromedical Evacuation Transport Service

(Reference Committee "F")

From the Essex County Medical Society

Whereas, the transportation by air of patients of the armed forces, known as the Aeromedical Transport Service, which proved to be the most efficient, rapid and safest during the World War II and the Korean conflict, was one of the primary factors in reducing the mortality and morbidity of casualties to the lowest level in history, and

Whereas, in recognition of this, the Department of Defense authorized and established this transportation system on a global scale so that any military patient, no matter where he is stationed in the world, may be flown within 24-48 hours to the most convenient hospital in the United States, when necessary, and

Whereas, this rapid transport of patients eliminated the necessity of building costly medical installations in bases overseas and staffing them with medical personnel and shipping large supplies to maintain them; it affords a far greater utilization of our existing government hospitals at home; it permits large numbers of doctors and nurses to serve at home instead of having to be sent abroad and at the same time it provides the best medical facilities of the United States for diagnosis and treatment to our military personnel overseas at tremendous savings, and

Whereas, in the event of a major disaster, air evacuation is now proved to be the most efficient method of collecting and transporting casualties to hospitals widely distributed so that treatment can be most quickly and thoroughly given without taxing or overburdening local or surrounding hospitals and their medical personnel, thus becoming one of the most efficient tools in civil defense, and

Whereas, in future war planning, the aeromedical evacuation system serves as a training school for pilots, flight nurses, and aeromedical technicians in the problems dealing with air transportation of the sick and wounded, and,

Whereas, among its many humane and life saving functions are the transportation of polio victims for the Polio Foundation and providing severely burned victims with equipment, personnel and facilities of the Burn Center at the Brooke Army Hospital applying the best known treatment within hours, therefore be it

Resolved, that the Essex County Medical Society is not only opposed to any curtailment or reduction of the activity of the Aeromedical Evacuation Transport Service but that this service be maintained in the highest state of training and efficiency, and be it further

Resolved, that a copy of this resolution be sent to The Medical Society of New Jersey for adoption and to instruct our delegates to introduce a similar resolution in the House of Delegates of the American Medical Association, and be it further

Resolved, that each echelon of organized

medicine, Essex County Medical Society, The Medical Society of New Jersey, the American Medical Association, notify the Department of Defense, Secretary of Air Dudley C. Sharp, Gordon W. Reed, Chairman of a 7-man committee, who are now studying the problem and will make final recommendations of the change in policy to curtail and ultimately eliminate the Aeromedical Transport Service, of their respective resolutions.

(Received by Board of Trustees 3/20/60, and referred to 1960 House of Delegates without prejudice)

Adopted (page 439)

10

Health Officer

(Reference Committee "F")

From the Passaic County Medical Society

Whereas, traditionally, physicians duly admitted to practice medicine in the State of New Jersey, have as such, been eligible to occupy the position of Health Officer, and

Whereas, by process of statute and regulations imposed by the Public Health Council, a physician is not now eligible to occupy the position of Health Officer without a license issued to him by the Public Health Council, which license is not obtainable without:

"Satisfactory completion of two years of full-time working experience in a position requiring administrative responsibility in a health department or some other public health organization approved by the State Department of Health for such experience.

Or

Satisfactory completion of one year of full-time planned working experience with the State Department of Health.", and

Whereas, the practical effect of this illogical requirement is to deprive physicians of the privilege of serving their communities as Health Officers, and deprives communities of the benefits to be derived from physicians occupying that position, therefore be it

Resolved, that the Legislature be requested to pass an appropriate amendment to the statute entitling physicians duly licensed in this state to serve as Health Officers without further license.

Substitute for first paragraph submitted by Passaic County:
"Whereas, traditionally, physicians duly admitted to practice medicine in the State of New Jersey, who have received the degree of Doctor of Medicine from an accredited and recognized college of medicine, have as such, been eligible to occupy the position of Health Officer, and"

Substitute resolution adopted (page 439)

11

Medical-Surgical Plan Payment to Dental Oral Surgeons

(Reference Committee "C")

From the Board of Trustees

Whereas, at a meeting of the Medical-Dental Liaison Committee on June 4, 1959, representatives of the New Jersey State Dental Society pointed out that the normal procedures in oral surgery presently being performed in New Jersey hospitals by licensed dentists specializing in oral surgery are not directly compensable under the Medical-Surgical Plan; and

Whereas, in consequence of this fact, in most instances the dental surgeons are therefore not being compensated at all for services thus rendered to Medical-Surgical Plan subscribers; and

Whereas, in many other states—as in New York, Pennsylvania and Delaware—compensation under Blue Shield is, in such cases, being directly made; and

Whereas, in the opinion of the Board of Trustees of The Medical Society of New Jersey the withholding of such direct payment to dental oral surgeons for such surgical services rendered to subscribers under Medical-Surgical Plan is inequitable and discriminatory, especially since the New Jersey State Dental Society is on record as entertaining no intention or desire to include general dentistry under the Medical-Surgical Plan; therefore be it

Resolved, that the House of Delegates of The Medical Society of New Jersey make specific exception in this instance to its request of 1958 to the Medical-Surgical Plan of New Jersey to continue the relaxation of payments of eligible benefits to persons holding full licenses to practice medicine in the State of New Jersey; and be it further

Resolved, that the House of Delegates of The Medical Society of New Jersey go on record as approving direct payment to dental oral surgeons by Medical-Surgical Plan for the normal procedures in oral surgery rendered in hospitals to subscribers of the Medical-Surgical Plan, and that it so inform the Board of Trustees of the Medical-Surgical Plan of New Jersey.

Adopted (page 435)

12

Technical Services by Non-Professional Personnel

(Reference Committee "E")

From the Board of Trustees

Whereas, the House of Delegates in 1959 referred back to the Board for further study the *amendment proposed to the Medical Practice Act (45:9-21, k) to include medical and/or x-ray technicians among those who, acting "in each particular case under the specific direction of a regularly licensed physician or surgeon," are not liable to the prohibitions of the chapter; and

Whereas, after careful consideration Society's legal counsel submitted to the Board the opinion that the objections offered in opposition before the House reference committee in 1959 "do not warrant interference with the proposed amendment"; and

Whereas, after protracted consideration, the Council on Legislation unanimously reaffirmed its support of the proposed amendment, the Legislative Analyst to the Council concurring; therefore be it

Resolved, that the House of Delegates reconsider the desirability of the introduction of the proposed amendment for purposes of its enactment into law.

*Proposed amendment (the amending language is underscored):

Medical Practice Act—45:9-21 (k) . . . A chiropodist, professional nurse, medical or x-ray technician, or a graduate physiotherapist, masseur, electrotherapist, or hydrotherapist, while operating in each particular case under the specific direction of a regularly licensed physician or surgeon. This exemption shall not apply to such assistants of persons who are licensed as osteopaths, chiropractors, optometrists or other practitioners holding limited licenses.

Referred, with Resolution #14, to Board of Trustees for action, with power to act (page 438)

13

Assembly Bill 556

(Reference Committee "E")

From the Mercer County Medical Society

Whereas, Assembly Bill No. 556 delegates the right to fix payments made to participating physicians in the Blue Shield Plan to the State Banking Commissioner instead of to the well-informed, non-salaried physicians of the Plan's Fee Committee and Board of Trustees, and in so doing disregards the fact that members of the medical profession are better qualified to weigh the merits of medical and surgical services; and

Whereas, it disregards the fact that the Medical-Surgical Plan of New Jersey is one of the most outstandingly successful in the nation, a circumstance which is due to the VOLUNTARY ASSOCIATION of approximately 80 per cent of the physicians of New Jersey, giving the 2,000,000 Blue Shield subscribers superb and incomparable care. It further disregards completely the fact that the more than 6,000 participating physicians have made and make the plan possible by accepting below average fees in full payment; and

Whereas, it disregards the traditionally free American custom of permitting a physician to dispose of his services on terms acceptable to his patients and to himself; and

Whereas, it is distinctly a piece of discriminatory class legislation; therefore be it

Resolved, that the members of the Mercer County Component Medical Society refuse to renew Medical-Surgical Plan contracts as participating physicians, should Assembly Bill No. 556 be enacted into law; and be it further

Resolved, that this resolution be presented to the Board of Trustees of The Medical Society of New Jersey for action at the next meeting of the House of Delegates in order that the physicians of New Jersey be urged to cooperate with its intent.

(Received as information by Board of Trustees, 4/24/60, and transmitted, in compliance with the expressed request, for consideration of the House of Delegates)

Not adopted (page 438)

14

Technical Services by Non-Professional Personnel

(Reference Committee "E")

From Radiological Society of New Jersey

Whereas, it is the desire of the Radiological Society of New Jersey to protect the x-ray technicians in this State; and

Whereas, this desire coincides with the purpose of the act to amend section 45:19-21 of the Revised Statutes; and

Whereas, the four words "medical or x-ray technician," as proposed, which are to be inserted in paragraph K, with the phrases qualifying them, would leave a loophole allowing for the operating of lay x-ray laboratories; therefore be it

Resolved, that paragraph K be altered to read as follows:

> "A chiropodist, professional nurse, medical technician, x-ray technician operating in a radiological installation maintained by a physician or surgeon, or in a radiological installation maintained by a hospital, or a graduate physiotherapist, masseur, electrotherapist, or hydrotherapist, etc."

The insertion of the words as underlined, in place of the words "medical or x-ray technician," in no way alters the intent of the proposed amendment, but at the same time protects the technician by placing him under direct control and supervision of the physician, and prevents any possibility of establishment of lay x-ray laboratories which would allow the use of a potentially dangerous, uncontrolled modality without direct control and supervision of a physician.

Referred, with Resolution #12, to Board of Trustees for action, with power to act (page 438)

15

David B. Allman, M.D. and William F. Costello, M.D.

(Reference Committee "G")

From Board of Trustees

Whereas, the Council on Medical Services of the American Medical Association has cited David B. Allman, M.D. and William F. Costello, M.D. for outstanding services rendered as members of its Committee on Aging and its Committee on Medical Facilities, respectively; and

Whereas, it is a matter of pride and satisfaction to The Medical Society of New Jersey that two of its members have so distinguished themselves; therefore be it

Resolved, that the House of Delegates of The Medical Society of New Jersey record its pride in the achievements of Doctor Allman and Doctor Costello as committee members of the AMA Council on Medical Service, and that it formally commend them for the honor that they have thus won for themselves and The Medical Society of New Jersey.

Adopted (page 441)

16

MSP Riders

(Reference Committee "C")

From Bergen County Medical Society

Whereas, extended benefits by rider are obtainable only by holders of certificates under group contracts of Medical-Surgical Plan of New Jersey, and

Whereas, it is desirable for all persons, including individual subscribers to be allowed to purchase these additional benefits, now therefore be it

Resolved, that The Medical Society of New Jersey urge Medical-Surgical Plan of New Jersey to offer for public sale all riders to their contracts now limited to group certificate holders, to the general public whether they are enrolled in groups or are individual subscribers, and be it further

Resolved, that this resolution be forwarded to The Medical Society of New Jersey for inclusion in the agenda of the next meeting of the House of Delegates.

Rejected [. . . agree in principle with resolution, and when studies indicate it is actuarially sound to include the wider coverage, that it be reconsidered.]
(page 435)

17

Fund Raising Organizations

(Reference Committee "E")

From Bergen County Medical Society

Whereas, many institutions, organizations and agencies compete for funds from the medical profession and the public, a considerable portion of these requests being devoted to actual and hypothetical needs in the fields of medicine and health, and

Whereas, because of the multiplicity of such requests and the lack of factual information the public is confused, funds are erratically allocated and worthy endeavors receive less than is their due; now therefore be it

Resolved, that The Medical Society of New Jersey accept the para-medical obligation of securing comprehensive financial, scientific, and sociological data that may, after adequate study, be used to acquaint our profession and the public concerning the need, the monetary efficiency of fund procurement and disposition, and the use of such funds as these several agencies obtain, and be it further

Resolved, that this resolution be forwarded to The Medical Society of New Jersey through channels for consideration by the House of Delegates at its Annual Meeting in May, 1960.

Amended: Substitute the words "American Medical Association" for "The Medical Society of New Jersey" wherever they appear; and substitute the word "June" for "May" in the last line.
Adopted as amended (page 438)

18

Assembly Bills 556, 612, and 60

(Reference Committee "E")

From Bergen County Medical Society

Whereas, with the introduction of Assembly Bills 556, 612, and 60 in the New Jersey State Legislature it becomes necessary to resist the invasion by legislative enactment of the freedom and rights of the members of the medical profession; be it

Resolved, that the Bergen County Medical Society go on record as opposing Assembly Bills 556, 612, and 60, and all similar legislation; and as supporting any official position or action of The Medical Society of New Jersey in opposition to these bills and any similar legislation which encroaches on the free practice of medicine by non-medical groups or individuals; and be it further

Resolved, that this resolution be presented to The Medical Society of New Jersey for introduction in the House of Delegates at the 194th Annual Meeting.

Alternate resolution submitted by Reference Committee:

Whereas, with the introduction of Assembly Bills 556, 612, and 60 in the New Jersey State Legislature it becomes necessary to resist the invasion by legislative enactment of the freedom and rights of the members of the medical profession; and

Whereas, the Bergen County Medical Society is on record as opposing Assembly Bills 556, 612, and 60, and all similar legislation; therefore be it

Resolved, that The Medical Society of New Jersey continue to oppose these bills and any similar legislation which encroach on the free practice of medicine by non-medical groups or individuals.

Alternate resolution adopted (page 438)

19

MSP-HSP Concurrent Rider for Diagnostic Services

(Reference Committee "C")

From a Fellow Delegate (Dr. Schaaf)

Whereas, 1) the basic Subscription Contracts of MSP and HSP do not cover the services which are primarily diagnostic although such coverage is eagerly desired by the public, and

2) the provision of such coverage for subscribers of the two Plans by separate riders would not only result in duplication of service and in competition between the Plans but would disturb the relationships among pathologists, radiologists and hospitals, and

3) concurrent riders (which would not be issued separately by either Plan) would supplement each other, and result in cooperation rather than in competition, and, in addition would make pathology and radiology services readily available to subscribers of both Plans throughout the State, and

4) the nature, time and place of utilization of such specialized services would be entirely at the discretion of the attending physician,

Therefore Be It Resolved that the House of Delegates endorse, in principle, the offering of a concurrent or joint rider for diagnostic services by MSP and HSP.

No action pending outcome of continued study by the Hospital Association and the Medical Society to evolve a method of payment by Blue Shield for diagnostic x-ray and diagnostic pathology in the outpatient department of the hospital at the direction of the attending physician (page 435)

20

Judicial Committee/Council Records

(Reference Committee "E")

From an Essex Delegate (Dr. Gullord)

Whereas, the Judicial Council of The Medical Society of New Jersey, in conjunction with the Judicial Committees of the component county societies, has performed a valuable service to the public and to the medical profession by satisfactorily disposing of many matters of controversy between patients and physicians, and

Whereas, the confidence and faith of the general public in organized medicine has been particularly fostered and encouraged by the assurance, pursuant to our Bylaws, that all matters brought to the attention of these bodies would be considered in strict confidence, and

Whereas, a recent ruling by the Superior Court of New Jersey has held that the transactions, records, and minutes of these bodies are not privileged, but are subject to subpoena and scrutiny by other than the Judicial Council and the various Judicial Committees and their attorneys; therefore be it

Resolved, that the Board of Trustees of The Medical Society of New Jersey refer this problem to their appropriate committee, and also to their legal counsel, for the purpose of exploring the possibility of securing suitable legislation to preserve the efficacy of this important function by granting the immunity of privilege to all procedures of the Judicial Council and the Judicial Committees of the various component county societies.

Adopted (page 438)

MEMORIAL

Samuel Allison Cosgrove, M.D.

Whereas, Almighty God has seen fit to summon from our midst His good servant and our beloved colleague Samuel Allison Cosgrove, M.D.; and

Whereas, in his long professional career as an obstetrician and gynecologist of national and international reputation, Doctor Cosgrove served as a leader and exemplar in his various capacities as practitioner, teacher, humanitarian, and administrator; and

Whereas, by his contributions and efforts he was instrumental in bringing about great advances in the areas of maternal and infant welfare; and

Whereas, despite his manifold activities and interests, for two score years he served faithfully as a delegate from Hudson County to The Medical Society of New Jersey; therefore be it

Resolved, that the House of Delegates of The Medical Society of New Jersey, recognizing Samuel Allison Cosgrove, M.D., as a man of personal virtue and professional eminence, record its grief at his passing; and be it further

Resolved, that a copy of this resolution be spread upon the minutes of this meeting, and that another copy, suitably prepared, be presented to his bereaved family.

Adopted (page 441)

Nominations for Emeritus Membership

(Reference Committee "G")

The following nominations for election to emeritus membership at the 1960 Annual Meeting have been received from the component societies. Conforming to the provisions of Article IV, Section 6, of the Constitution, all nominees are now and have been members in good standing for at least twenty years, and by reason of age or infirmity have retired from the active practice of medicine. All are emeritus members of their respective component societies.

BERGEN COUNTY

Charles D. Cropsey, Rutherford; age 90

ESSEX COUNTY

Charles A. Breitstadt, Newark; age 70
Joseph Chiaramida, Brooklyn, N. Y. (formerly Verona); age 69
Katharine B. Hahn, South Orange; age 62
George E. Kalter, Bradenton, Fla. (formerly Maplewood); age 68
Ralph W. Walton, Montclair; age 73

MORRIS COUNTY

Harold S. Hatch, Winter Park, Fla. (formerly Morristown); age 69

OCEAN COUNTY

Robert Buermann, Lakewood; age 72

SOMERSET COUNTY

Theodore M. Silverman, Somerville; age 68

UNION COUNTY

Stanton H. Davis, Cambridge, Md. (formerly Plainfield); age 66
William B. Fort, Pompano, Fla. (formerly Plainfield); age 67
William H. McCallion, Spring Lake (formerly Elizabeth); age 69
Grace M. Robertson, Plainfield; age 75
Stephen Steele, Woodstock, N. H. (formerly Linden); age 64
Frank A. Williams, Elizabeth; age 69

Adopted (page 441)

Medical Service Administration of New Jersey

(Reference Committee "C")

Royal A. Schaaf, M.D., President, Board of Governors

During 1959, the activities of Medical Service Administration of New Jersey have been concerned with the City of Newark Medical Plan and the Medicare Program of the United States Government.

NEWARK MEDICAL PLAN

The Newark Medical Plan provides for medical services rendered in the homes of eligible persons by physicians of the patient's choice on a fee-for-service basis; it is designed to meet the needs of the indigent and medically indigent on a "cost plus" rather than on an insurance basis.

The Plan is an example of how the problem of public medical care of the indigent and medically indigent may be successfully solved through the cooperation of an official health agency with a voluntary non-profit agency established by the medical profession.

The following statistics present the experience of the Plan over a five year period from 1955 to 1959 inclusive. (Amounts from 1944 to 1954 are listed in previous reports).

The classification of *indigent* is applied to those whose names appear on the Welfare Rolls of the City of Newark; the *medically indigent* are those who are considered by the City Division of Health as having sufficient income to meet the routine of an adequate standard of living, but lack sufficient income to pay for needed medical care.

The increase in the mean number of persons on the Welfare Rolls with its resultant increase of approved medical services can be attributed to a sharp upswing in the economy with accompanying drop in employment, and to the gradual increase in the population of the City of Newark. Although the number of medically indigent cases *decreased* about 7 per cent, the cost of approved medical services for this class of patient *increased* approximately 6½ per cent; this is due to many instances of multiple patients seen on individual visits.

Fifty-one physicians participated in the program during 1959.

The Essex County Medical Society has cooperated by supplying new physicians to the panel available to serve the needy of the City of Newark on a twenty-four hour basis.

The Plan has proceeded smoothly with no change in operation or policy in the past year.

MEDICARE PROGRAM

Medical Service Administration of New Jersey, as the fiscal agent of The Medical Society of New Jersey, completed its third year of administration of the physicians' portion of the Medical Care Program for dependents of members of the armed services which was implemented by the Department of the Army on December 7, 1956. Under this program, wives (or dependent husbands) and children

INDIGENT (RELIEF) PERSONS

Year	1955	1956	1957	1958	1959
Mean number of persons on Welfare Rolls during year	5281	3883	4262	6626	7026
Number of cases served	1964	1277	1556	1655	2154
Value of approved services	$6,565.50	$4,605.00	$7,000.50	$7,630.00	$10,791.00
Cost per capita of relief load	1.24	1.19	1.57	1.15	1.50
Cost per case per year	3.34	3.60	4.54	4.61	5.00

MEDICALLY INDIGENT CASES*

Number of cases served during year	3335	2993	4291	3703	3425
Value of approved services	$11,151.00	$9,969.00	$17,662.50	$15,420.00	$16,439.00
Cost per case per year	3.34	3.33	4.11	4.16	4.80

* The word "case" here means "family" as distinguished from "person" referred to under the report on number of "persons on welfare rolls" above.

of persons in military service are entitled to medical and surgical services from civilian physicians and hospitals at government expense.

We believe that the experience of the first two years of operation pointed the way to a smoother and more efficient system of handling claims, thereby eliminating the main cause for complaints.

A review of the accomplishments of the Medicare Program in New Jersey since its initiation in December 1956 is presented herewith:

CLAIM EXPERIENCE

Period	Received	Declined	Returned As Incomplete	Paid Claims	Paid Amount	On Hand
Dec. 7. 1956-Dec. 31, 1957	10,017	320	3,179	5,982	$ 489,265	536
Jan. 1. 1958-Dec. 31, 1958	14,014	377	3,758	9,298	778,551	1,084
Jan. 1, 1959-Dec. 31, 1959	7,384	385	1,972	5,908	494,691	206
TOTAL	31,415	1,082	8,909	21,188	$1,762,507	206

1,770 New Jersey physicians received fees for services performed for beneficiaries of the Medicare Program during the year 1959, as compared to 2,005 during 1958 and 1,675 during 1957.

Of the claims paid in 1959 about 76 per cent were for maternity care, 15 per cent for pediatric care, 5 per cent for surgical care and 4 per cent for miscellaneous illness and conditions.

The restriction of benefits, which became effective October 1958, influenced the 4 per cent decline in claims received during 1959 as compared to 1958.

ADMINISTRATIVE EXPENSE

Period	Amount	Per Case
Dec. 7/56-June 30/57	$19,670	$11.44
July 1/57-June 30/58	28,796	3.22
July 1/58-June 30/59	31,983	3.77
July 1/59-Dec. 31/59	8,312	4.10
TOTAL	$88,761	

The administrative expense data tabulated above, reflect the initial costs of the program (contract negotiation, printing, distribution of manuals, and training), and the subsequent additional costs of printing and distribution of new manuals and schedules of allowances incurred by the restriction of benefits which became effective October 1958. The lowered volume of claims and more or less static administrative costs account for the higher rate during the six month period of July 1959 to December 1959.

In New Jersey, Army dependents represented approximately 35 per cent of the total number of cases, the Navy about 33 per cent and the Air Force about 20 per cent. The Marine Corps, Coast Guard, Public Health Service and the Coast Geodetic Survey—the remaining classes of those whose dependents are eligible for federal Medicare coverage—accounted for the remainder.

On the third anniversary of the Medicare Program, Brigadier General Floyd L. Wergeland, Executive Director of the Office for Dependents' Medical Care, reported more than $200 million had been expended on the national level for civilian medical and hospital services to 800,000 dependents of military personnel since the inception of the program on December 7, 1956. Physicians have received 51 per cent of the outlay and hospitals 49 per cent.

A modification, renewing and extending the Medicare Contract to June 30, 1960, was executed by The Medical Society of New Jersey and Medical Service Administration of New Jersey with the United States Government, Department of the Army, under date of July 1, 1959.

Subsequently, Medical Service Administration of New Jersey, as fiscal Administrator, renewed the subcontract with the Hospital Service Plan of New Jersey for the performance at cost of the administrative services under the Prime Contract, which services are being performed in the name of Medical Service Administration of New Jersey.

RESTORATION OF RESTRICTED BENEFITS

Effective January 1, 1960, certain of the benefits that were curtailed in October 1958 by Congressional action were restored as follows:

Dependents *residing apart from sponsor,* (the uniformed serviceman) will continue to be allowed selection of either uniformed services facilities or civilian medical sources for care authorized under the program.

Dependents *residing with sponsor* will continue to utilize an available uniformed services facility in the area in which residing. When such facilities are not available, a *Medicare Permit* (DD Form 1251) will be furnished such dependents by the appropriate commander authorizing them to seek medical care from civilian sources. The issuance of the *Medicare Permit* places the dependent residing *with sponsor* in essentially the same free choice position as a dependent residing apart from sponsor. The permit is limited to immediate use in a current illness, injury or condition.

Surgical services that may be planned or elected, which, in the opinion of the cognizant medical authority, (the charge physician) are medically indicated.

Out-patient care, including diagnostic and therapeutic tests and procedures authorized by the attending physician, *but limited* to treatment of fractures, dislocations, lacerations, and other wounds as prescribed in the Schedule of Allowances.

Acute emotional disorders constituting emergency in-hospital treatment will be payable when the acute emotional disorder becomes a threat to the life or health of the patient.

All of the above services are subject to certain exceptions outlined in detail in our Bulletin MSA-B-52 which was distributed to the physicians of New Jersey on December 22, 1959.

The Schedule of Allowances for services performed under the Medicare Program was negotiated by the Special Medicare Committee of The Medical Society of New Jersey with the Department of the Army; in no instance is an agreed upon fee less than that provided by The Medical-Surgical Plan of New Jersey for a particular procedure.

Provisions have been made for adjustments that may occur when a physician believes he is entitled to a fee higher than that permitted under the Schedule of Allowances. In such instances the physician is requested to submit a special report to Medical Service Administration, which report in turn, is referred to the Special Medicare Committee of The Medical Society of New Jersey for review and recommendation. After careful review, the Committee's recommendation is then returned to Medical Service Administration, and submitted with the physician's claim to the Federal Government for review. The amount approved for payment to the physician is then remitted by Medical Service Administration.

At this point, we again wish to commend the members of the Special Medicare Committee of The Medical Society of New Jersey for their conscientious consideration of each case submitted for review and recommendation. With but few exceptions, the Office for Dependents' Medical Care has concurred in the recommendations of the Committee.

In its operation of the City of Newark Medical Plan on a municipal level, and the Medicare Program on a Federal level, Medical Service Administration of New Jersey has demonstrated its importance and value as an organization through which medical and surgical care may, by arrangements with Governmental agencies at Federal, State or other levels, be made available to individuals and groups not eligible for insurance protection against illnesses on a non-profit voluntary prepayment basis, and is designed to preserve the patient-physician relationship and allow free choice of physician and patient.

The Board of Governors of Medical Service Administration of New Jersey again wishes to express to The Medical Society of New Jersey its appreciation of and thanks for the continued moral and financial support so generously given to the Administration during the nineteen years of its existence.

Adopted (page 435)

Medical-Surgical Plan of New Jersey

(Reference Committee "C")

ROYAL A. SCHAAF, M.D., President, Board of Trustees

MESSAGE FROM THE PRESIDENT ON BEHALF OF THE BOARD OF TRUSTEES OF MEDICAL-SURGICAL PLAN

On the following pages, a factual presentation of the achievements of Medical-Surgical Plan of New Jersey, New Jersey Blue Shield Plan, for the year of 1959, is set forth by the Plan's management and Board of Trustees for the information of members of the medical profession. With several of the items thus represented, considerable satisfaction may be felt by all concerned. Others, however, give grounds for the most serious and thoughtful consideration of the future of a Plan which, without question, has earned a unique standing as New Jersey's leading form of non-profit prepaid medical-surgical sickness insurance.

On the "plus" side of the ledger, it should be noted that the Plan established all-time records for benefit payments and volume of claims processed during the year just past . . . two criteria by which *service* to our subscribers and their covered dependents can be most effectively measured.

Another encouraging sign is the continuing substantial increase in enrollment. New Jersey Blue Shield Plan is fast approaching the two-million mark in membership, completing 1959 with 1,954,215 individuals covered. The increase of more than 123,000 new members in 1959 enabled New Jersey Blue Shield to maintain its position as the seventh largest of the 73 Blue Shield Plans . . . and affirmed beyond the possibility of refutation that New Jersey residents continue to regard our Plan as an outstanding value in health protection.

Other items of progress during 1959 are worthy of note. Headway was made during the year on development of a "Senior Citizen" contract as advocated by The Medical Society of New Jersey and the American Medical Association, and at year's end there were grounds for optimism that some such coverage for persons age 65 and over, may become available in the not-too-distant future. Another significant advance was the introduction of three "riders" to the basic Blue Shield contracts held by group subscribers, by which extended benefit coverage may be obtained at slight extra cost.

It would certainly not be prudent, however, to dwell at length upon the sunny side of the Blue Shield picture without taking into consideration developments which make advisable concentrated study and planning by those who are interested in the future of the Plan. Most prominent of these, of course, was the reminder, as indicated in the accompanying financial statement, that the continuing financial soundness of the Plan requires a re-evaluation of the present structure of rates and benefits.

It will be noted that the year's activities required withdrawal of $2,374,943 from reserves . . . reducing such funds from about $11 million at the end of 1958 to approximately $8.6 million. While such reserve funds are still ample for foreseeable contingencies, it is obvious that corrective steps must now be implemented. The Plan has been forced to seek necessary additional income through a rate adjustment only once since 1949 . . . that being in 1956 when a new contract was issued providing additional benefits to members . . . but sound economics now seem to dictate such action for the future.

Elsewhere in this report are presented additional data highlighting the year's activities which are of interest to members of The Medical Society of New Jersey, subscribers and to the public at large. As always, questions and comments will be welcomed by the Plan's officers and trustees.

I would be remiss, indeed, were I to conclude these opening remarks without extending again sincere appreciation for the cooperation, loyalty and understanding of our Participating Physicians . . . the devoted and efficient activities of our operating staff . . . and to the Hospital Service Plan of New Jersey for the continuing service in matters involving the Blue Shield Plan.

Organized 1942

MEDICAL-SURGICAL PLAN OF NEW JERSEY

COMPARATIVE STATEMENT
As of December 31

ASSETS

	1959	1958
Cash	$ 182,061	$ 659,878
Accounts Receivable—Subscriptions	530,449	461,069
Accounts Receivable—Hospital Service Plan	190,953	57,337
Accounts Receivable—Other	28,249	22,617
Accrued Interest and Dividends Receivable	111,112	123,426
Investments	13,634,121	15,443,413
TOTAL ASSETS	$14,676,945	$16,767,740
LIABILITIES		
Payable for Medical-Surgical Claims	$ 4,756,000	$ 4,550,000
Unearned Subscriptions	1,231,583	1,160,939
Other Liabilities	57,320	49,816
TOTAL LIABILITIES	$ 6,044,903	$ 5,760,755
RESERVES FOR THE PROTECTION OF SUBSCRIBERS		
Securities Evaluation	$ 336,000	$ 200,000
Special Contingency	100,000	100,000
Unassigned	8,196,042	10,706,985
TOTAL RESERVES	$ 8,632,042	$11,006,985
TOTAL LIABILITIES AND RESERVES	$14,676,945	$16,767,740

ANNUAL STATISTICS 1959

TABLE I

PAID 1959

	Services				
	Primary Services	Total Services	% (All Services)	Payment	%
Surgical	191,272	227,388	45.5%	$15,524,233	52.3%
Medical	76,290	89,466	17.9	5,756,542	19.4
Obstetrical	44,399	45,988	9.2	5,471,255	18.4
Consultation	—	29,431	5.9	451,983	1.5
Anesthesia	—	107,471	21.5	2,505,994	8.4
TOTAL	311,961	499,744	100.0%	$29,710,007	100.0%

TABLE II

AVERAGE PAYMENT PER PRIMARY SERVICE (Service)—Paid 1959

Surgical	$ 81.16
Medical	75.46
Obstetrical	123.23
Consultation	(15.36)
Anesthesia	(23.32)

TABLE III

DISTRIBUTION OF EARNED SUBSCRIPTION INCOME

		%
Earned Subscription Income	$29,631,426	100.0
Incurred Claims	29,916,007	101.0
Surgical	15,646,072	52.8
Medical	5,803,705	19.6
Obstetrical	5,504,545	18.6
Consultation	448,740	1.5
Anesthesia	2,512,945	8.5
Operating Expense	2,545,431	8.5
Decrease in Reserve	2,830,012	(9.5)

TABLE IV

Percentage Distribution of Earned Income

	%
Incurred Claims	101.0
Operating Expense	8.5
Withdrawal from Reserve	(9.5)

ADDITIONAL CLASSIFICATION OF INCURRED CLAIMS BASED ON DISTRIBUTION OF PAID CLAIMS FOR 1959

		%
Total Incurred 1959	$29,916,007.00	101.0
Surgical	15,646,072.00	52.8
Medical	5,803,705.00	19.6
Obstetrical	5,504,545.00	18.6
Consultation	448,740.00	1.5
Anesthesia	2,512,945.00	8.5

DISTRIBUTION OF DOLLAR OF INCOME

	Cents
Surgical	52.8
Medical	19.6
Obstetrical	18.6
Consultation	1.5
Anesthesia	8.5
Operating Expenses	8.5
Total of above	109.5
Withdrawn from reserves	—9.5
	100.0

INCIDENCE RATE PER 1000 PERSONS ENROLLED

1942	40
1945	86
1948	96
1951	112
1954	126
1956	143
1958	153
1959	165

CLAIMS INCURRED

Year	Dollars
1942	5,395
1945	208,208
1948	1,203,652
1951	6,527,375
1954	13,991,592
1956	18,960,672
1958	25,037,986
1959	29,916,007

COMPARATIVE SUMMARY OF OPERATIONS

	1959		%	1958		%
Subscriptions Earned		$29,631,426	100.0		$29,228,537	100.0
Less:						
Claims Incurred	$29,916,007		101.0	$25,037,986		85.7
Operating Expenses	2,545,431		8.5	2,382,649		8.2
		32,451,438	109.5		27,420,635	93.9
Gain or (Loss) from Underwriting Operations		$(2,830,012)	(9.5)		$ 1,807,902	6.1
Income on Investments		443,571			441,961	
Operating Gain or (Loss) for the Year		$(2,386,441)			$ 2,249,863	

SUMMARY OF RESERVES FOR PROTECTION OF SUBSCRIBERS

Reserves at January 1	$11,006,985	$ 8,778,817
Operating Gain or (Loss) for the Year	(2,386,441)	2,249,863
	$ 8,620,544	$11,028,680
Plus: Change in Non-Admitted Assets	11,498	—
Less: Change in Non-Admitted Assets	—	21,695
Reserves at December 31	$ 8,632,042	$11,006,985

HIGHLIGHTS OF PLAN OPERATIONS 1959-1958

Subscriptions Earned by the Plan Increased in 1959 over 1958 by	$ 402,889
Subscribers Claims Incurred by the Plan Increased in 1959 over 1958 by	4,878,021
Operating Expenses Increased in 1959 over 1958 by	162,782
In addition, based on Subscriptions Earned, 1959 showed a percentage increase of	0.3%
Reserves for the Protection of the Plan's Subscribers Decreased in 1959 under 1958, as follows:	$ 2,374,943

NEW JERSEY PARTICIPATING AND NON-PARTICIPATING PHYSICIANS BY COUNTY

	PARTICIPATING				NON-PARTICIPATING		Total Eligible	% P.P. As Of	% P.P. As Of
COUNTY	M.D.	D.O.	D.S.C.	Total	M.D.	D.O.	Phys.	12-31-59	12-31-58
Atlantic	172	15	12	199	21	0	220	90.4	89.1
Bergen	529	42	31	602	265	9	876	68.7	67.2
Burlington	106	13	7	126	20	4	150	84.0	83.8
Camden	320	72	21	413	51	4	468	88.2	87.0
Cape May	47	7	2	56	6	2	64	87.5	86.6
Cumberland	92	3	7	102	4	1	107	95.3	91.5
Essex	1287	52	72	1411	279	13	1703	82.8	82.6
Gloucester	67	12	7	86	13	5	104	82.7	79.3
Hudson	572	9	36	617	132	4	753	81.9	80.4
Hunterdon	50	0	0	50	3	0	53	94.3	92.7
Mercer	331	8	15	354	56	5	415	85.3	84.5
Middlesex	262	6	15	283	56	0	339	83.5	81.9
Monmouth	277	17	14	308	59	2	369	83.4	80.4
Morris	211	9	9	229	50	4	283	80.9	79.7
Ocean	69	5	3	77	12	0	89	86.5	86.2
Passaic	417	12	29	458	131	2	591	77.5	76.4
Salem	50	4	2	56	2	0	58	96.5	94.2
Somerset	103	2	3	108	19	0	127	85.0	80.3
Sussex	37	3	2	42	5	1	48	87.5	83.3
Union	378	23	36	437	183	5	625	69.9	71.7
Warren	43	2	0	45	5	0	50	90.0	87.5
Out of State	138	13	0	151	0	0	151	—	—
Totals	5558	329	323	6210	1372	61	7643	81.2	80.3

ENROLLMENT GROWTH

Year	Enrollment
1942	4,131
1945	49,441
1948	236,604
1951	669,906
1954	1,196,804
1958	1,803,397
1959	1,954,215

PHYSICIAN RELATIONS PROGRAM

The number of personal contacts with physicians made by the Plan's Field Representatives increased in 1959 over those made in 1958. One of the major features of this program is the scheduling of at least one visit a year with medical staffs of general hospitals throughout the state. This is accomplished by pre-arrangement with Administrators and Chiefs of Staff of individual hospitals for the establishment of an information desk in the doctors' lounge or by an invitation to address a Medical Staff Meeting. During the past four years there has been a steady increase in the number of invitations to the Field Representatives to address Medical Staff Meetings. This method of personal communication with physicians has many advantages; one of which is that it enables the representatives to communicate many of the Plan's policies, procedures and other matters of general interest to a large number of physicians in a relatively short period of time.

The primary purpose of this program is to disseminate Plan policy and to advise physicians of current changes in rules and regulations and in the Schedule of Maximum Plan Payments. The representatives also invite questions from physicians in an effort to assist them in solving problems which arise in the course of their individual dealings with the Plan.

During the past year a new avenue for broader communication was attained. This was brought about by invitations to Field Representatives to address meetings of county medical societies. By utilizing this new avenue of

communications, representatives of the Physician Relations Section addressed meetings of seven county medical societies. Reports received at the Plan from various members and officers of county medical societies indicate enthusiastic support for continuation of this phase of the program. This new avenue of communications appears to have been favorably received and will be continued as a regular portion of the field activities program.

During 1959, the total number of contacts made by the Physician Relations Section was 2,843. This represents an increase of more than 1,000 over those made in 1958.

OBJECTIVES IN 1960

Our primary objective in 1960 will be the acceleration of field contacts. Our present policy of visiting each hospital once a year will be increased with two and possibly three meetings in areas where repeated meetings are indicated or requested.

Our summer program will be geared to personal visits to doctors' offices, with concentration on new Participating Physicians and newly licensed physicians.

Attempts will be made to hold a meeting with each county medical society on an annual basis.

We anticipate a substantial increase in our contacts with doctors' office assistants. This will be accomplished by group meetings and visits to individual offices.

An earnest effort will be made to bring the above outlined program to a successful conclusion during the forthcoming year.

EXTENDED BENEFITS

Approval by the Department of Banking and Insurance made it possible for your New Jersey Blue Shield Plan to offer Riders for extended benefits to group subscribers effective July 1, 1959.

The following riders were offered:

Rider A providing:

Additional days of medical coverage in hospital.
Surgery out of hospital.
Diagnostic surgical procedures out of hospital.
Radium, Radon or Radioactive Isotope therapy.
X-ray treatments out of hospital.
Pathology out of hospital.
Diagnostic x-rays and/or Radioactive Isotope diagnostic studies.
Physical therapy out of hospital.

Rider B providing:

Additional days of medical coverage in hospital.

Rider C providing:

Surgery out of hospital.

Riders B and C may be purchased separately or in combination with the proviso that all group members purchase the same coverage.

Sufficient time has not passed in order to accurately evaluate the Plan's experience or incidence rate of utilization of these extended benefits. However, it is interesting to note that at year end 16,011 riders had been sold covering approximately 34,754 persons. Nearly one-half of the riders in force are rider A which provides the most complete coverage.

1959 BOARD OF TRUSTEES

Charles W. Barkhorn, M.D.	1952
Irving P. Borsher, M.D.	1950
Robert G. Boyd	1957
Charles L. Cunniff, M.D.	1958
Joseph P. Donnelly, M.D.	1953
Joseph I. Echikson, M.D.	1959
Jerome G. Kaufman, M.D.	1954
Joseph M. Keating, M.D.	1953
Samuel J. Lloyd, M.D.	1958
Arthur W. Lunn	1951
Paul Mecray, Jr., M.D.	1953
Duane E. Minard, Jr.	1957
Glennis S. Rickert, M.D.	1959
Royal A. Schaaf, M.D.	1942
Rudolph C. Schretzmann, M.D.	1945
James H. Spencer, M.D.	1957
Edward W. Sprague, M.D.	1942
John S. Thompson	1942
Thomas J. White, M.D.	1951
Carl K. Withers	1952

ADVISORS TO THE BOARD OF TRUSTEES

		Term as Board Members
Harry N. Comando, M.D.	1959	1942-1958
*Samuel A. Cosgrove, M.D.	1953	1943-1953
William F. Costello, M.D.	1958	1948-1958
William E. Dodd, M.D.	1952	1944-1952
Elton W. Lance, M.D.	1951	1942-1951

Note: *Appointment Year Shown After Name.*

FORMER MEMBERS OF THE BOARD OF TRUSTEES

David B. Allman, M.D.	1945-1945
*Theophilus H. Boysen, M.D.	1944-1945
Lewis W. Brown, M.D.	1949-1954
*William J. Carrington, M.D.	1942-1943
*Patrick H. Corrigan, M.D.	1952-1958
*William K. Harryman, M.D.	1944-1945
Sigurd W. Johnsen, M.D.	1950-1951
*Augustus S. Knight, M.D.	1942-1948
*Thomas K. Lewis, M.D.	1942-1949
*Norman M. Scott, M.D.	1942-1950
Reuben L. Sharp, M.D.	1950-1951

*Deceased

Adopted (page 434)

REFERENCE COMMITTEE REPORTS

Reference Committee "A"

John J. Torppey, M.D., Chairman

1. The *President's* report (page 357) was discussed and approved. The members of Reference Committee "A" present were: John J. Torppey, William E. Dodd, Alan A. J. Stolow, and Elbert H. Progue who wish to comment favorably on the wonderful job done by Dr. Bowers. It is evident from the President's report that the office of the President today requires a tremendous amount of time, effort and sacrifice of personal considerations. We feel that Dr. Bowers has shown the attributes most desirable in medicine during history in office.

Adopted

2. The report of the *Board of Trustees* (page 363) was discussed with the Reference Committee by Dr. Luke Mulligan, Chairman of the Board of Trustees.

Adopted

The Reference Committee agrees with the report of the Board of Trustees on *"Conflicting Policy Actions"* (page 364) and feels that this matter should be emphasized and brought to the attention of the Component County Societies and various specialty groups.

Adopted

3. The report of the *Secretary* (page 362) was discussed and approved. With regard to the section on "Vacancies in the House of Delegates," it was noted that 125 duly elected delegates did not attend the meetings of the 1959 House of Delegates, and that of these 125 absentees, 73 were again absent at the special session of the House of Delegates held March 13, 1960 in Trenton.

Reference Committee "A" would like to emphasize the importance of delegates' attending the sessions of the House of Delegates and of county medical societies' choosing as delegates those members who are able and willing to attend.

Further, when of necessity attendance by a delegate is impossible, attendance by the alternate delegate should be assured.

The Secretary is to be commended on the completeness of his report and the zeal and thoroughness with which his duties have been carried out during the past year.

Adopted

4. The report of the *Judicial Council* (page 373) was discussed and approved. The very nature of the work of this Council requires wisdom and tact. We wish to commend the Judicial Council on the clarity of the opinions rendered on the controversial matters considered.

Adopted

5. The report of the *Executive Officer* (page 378) was presented by Mr. Nevin.

The report was approved as read. As usual the report was thorough and contained much that was thought-provoking, and, as in the case of the President's report, gives an insight into the size and scope of the operations of The Medical Society of New Jersey.

Adopted

6. The report of the *Committee on Revision of Constitution and Bylaws* (page 395) concerning *vacancies in the House of Delegates* was read and approved.

Adopted

Adopted as a Whole

Reference Committee "B"

Gerard R. Gessner, M.D., Chairman

Reference Committee "B" met in Room 1344 at 11:00 a.m., May 15, 1960. Present were: Dr. Gerard R. Gessner, chairman; Dr. John J. Bedrick, Dr. Morton F. Trippe, Dr. Nicholas A. Marchione, and Dr. Henry O. von Dielen.

1. The annual report of the *Treasurer,* Dr. Rudolph C. Schretzmann (page 359) was the first item on the agenda. There were present an erudite group of physicians who brought out several items in the course of discussion which indicated the sense of interest in the fiscal policies of the Society. Without becoming wordy in our report, their questions were excellently answered by the Treasurer. He reported that there is annually an independent audit of all our accounts, and it was gratifying to the reference committee to hear that all disbursements of Society funds are made by check, appropriately vouchered. Some disbursements by cash, properly budgeted, are dispensed at the State office, and this information should dispel any rumors to the contrary.

The reference committee at this time would like to recommend special commendation to Dr. Schretzmann for his able administration of an onerous task since he was elected to the office. It was stated by a member of the Board of Trustees that he probably has been the best Treasurer the Society ever has been fortunate enough to have in the office. He has with painstaking devotion attended to his office in a manner that can hardly be excelled. His management of our half million dollar enterprise has been outstanding. His choice of investments has been most wise, and he has handled our funds as though they were his own, giving unstintingly of his time and energy. He deserves an accolade of thanks not only by this House of Delegates but every member of this Society for a job well done.

The committee recommends that the report of the Treasurer be accepted and approved.

Adopted

2. Your committee then reviewed the annual report of the *Committee on Finance and Budget* (page 383) under the chairmanship of Dr. David B. Allman. The budget was reviewed in its entirety, as it appears on the mimeographed forms in the hands of each delegate. Obviously this is brief, and the items are grouped under separate but applicable headings. All the items are based on sound decision, and the reference committee does not feel that any excesses have been indulged.

It was felt by your reference committee that it is appropriate to mention that under item D-1 the Board of Trustees voted a $5,000 annual honorarium to the President of this Society. It is felt that this is not only a prudent but a wise decision, as all of you are aware of the tremendous financial burden placed on this individual. If we are to continue to have elected to this honorable office the men of merit it deserves, this practice should meet with unanimous approval.

Your reference committee would also like to recommend a special commendation to Mrs. Edith L. Madden and her staff for the long hours of preparation of the extensive detail of the report of the Committee on Finance and Budget. Your reference committee would like again to commend Dr. Allman and his committee for its continued great service to the Society in the preparation of his report at this time.

The committee recommends approval of the budget for 1960-61 in the amount of $204,279.

Adopted

3. *American Medical Education Foundation* (page 383)—The Committee on Finance and Budget recommended: that the per capita level of contribution to A.M.E.F. for 1961 be set by the House of Delegates in addition to, and not as part of, the budgetary assessment, and that both be paid at the same time.

As last year, your reference committee recommends the assessment for this contribution be $5.00 per capita, to be included with the per capita assessment of the State Society.

Adopted

4. Your reference committee recommends that the 1961 *assessment* be adopted at $35 per capita, with no provision for the contribution for A.M.E.F., this item having been attended to in the previous recommendation.

Adopted

5. JOURNAL—The *Publication Committee* (page 388) is commended for its continued excellent financial status. Again, no budget appropriation has been requested for the publication of THE JOURNAL, JOURNAL office expenses, and travel. The Publication Committee will continue to operate on its advertising income.

Adopted

6. *Medical Student Loan Fund*—The annual report of the Medical Student Loan Fund Committee (page 387) was reviewed. Dr. Luke A. Mulligan, as chairman of the Fund, and his committee have, and are still performing an outstanding service to this Society in the management of this all-important area.

The committee recommends that Dr. Mulligan and his Medical Student Loan Fund Committee at State level be congratulated for the excellent performance of a duty which takes time, knowledge, and effort.

Adopted

Adopted as a Whole

Reference Committee "C"

John J. Thompson, M.D., Chairman

Reference Committee "C" met at 11:00 a.m., May 15, 1960 in the Mandarin Room. Present were: Winton H. Johnson, M.D., A. Guy Campo, M.D., David Eckstein, M.D., Henry J. Konzelmann, M.D., and John J. Thompson, M.D.

The committee was well attended by members of the House of Delegates and members of the Medical Society. Their welcomed comments were carefully weighed. The meeting adjourned at 4:15 p.m., May 15, 1960.

1. The annual report of *Medical-Surgical Plan of New Jersey* (page 427) was approved as contained in the printed material given to the House of Delegates. We wish to commend Medical-Surgical Plan for a job well done.

Adopted

2. The report on *Health Care of the Aged* (page 364) referred to the reference committee from the Board of Trustees was given unanimous approval. We would like to encourage physicians to support this plan for the care of aged. It is the feeling of the committee that this is a constructive measure for the Health Care of the Aged and will combat such legislative moves as the Forand bill.

Adopted (split vote)

3. The committee gave its unanimous approval to the recommendation of the Board of Trustees (page 366) that the President of The Medical Society of New Jersey should serve as a Trustee of Medical-Surgical Plan of New Jersey, and we feel it is a forward step.

Adopted

4. The supplemental report of *nominations* on the *Board of Trustees of Medical-Surgical Plan of New Jersey* (page 372) for 1960-61 was given unanimous approval by the committee.

Adopted (split vote)

5. The recommendation concerning *Medical-Surgical Plan Payment to Chiropodists* (page 365) was given unanimous approval. It was established that any change in the present plan for payment to chiropodists would necessitate a repeal of the 1953 amendment to the Enabling Act, and we feel that the best interests of medicine are being served by not advocating this repeal at this time.

Adopted

6. The report from the Board of Trustees concerning further investigation of *Paid-up Policies in Blue Cross and Blue Shield* (page 365) was given unanimous approval.

Adopted

7. Unanimous approval of the committee was given to the report concerning *M.S.P. Public Relations Counsel* (page 365) and we concur in the requirement that spokesmen for the Hospital Service Plan make no public statements regarding Blue Shield policies and contracts—current or proposed—except with the consent and approval of Medical-Surgical Plan.

Adopted

8. The committee has voted unanimously to reject the recommendation from the Board of Trustees on *Blue Cross and Blue Shield Riders for Diagnostic Services* (page 372) which reads as follows:

> The Board of Trustees recommends to the House of Delegates that it approve the proposal that Medical-Surgical Plan of New Jersey agree to discontinue the issuance of diagnostic riders provided that Hospital Service Plan of New Jersey will also agree to make no effort to achieve the issuance of a diagnostic rider under Blue Cross coverage.

We apologize to the Board of Trustees for not sustaining its recommendation, but we have rejected it for the following reasons:

> It is the reference committee's feeling that the action of the House of Delegates taken on March 13, 1960 did not authorize the discontinuance of the Blue Shield Rider for diagnostic services—"Rider A". The committee further feels that the discontinuance of the diagnostic rider would be an injustice to the public.

The committee, by rejecting this recommendation, recognizes that the sale of the Medical-Surgical Plan "Rider A" for diagnostic x-ray and diagnostic pathology will continue.

Adopted (split vote, 166 to 90)

Secondly, we further recommend continuing the study by the Hospital Association and The Medical Society of New Jersey to evolve a method for payment by Blue Shield for diagnostic x-ray and diagnostic pathology done in the outpatient department of the hospitals at the direction of the attending physician.

The committee wishes further to emphasize that the success or failure of this rider is under the

direct control of the attending doctor, in that he must exercise the most ethical and moral code in referring his patients for these services to best implement the medical care of his patient.

Adopted

9. This committee recommends that no action be taken by the House of Delegates on *Resolution #19—MSP-HSP Concurrent Rider for Diagnostic Services* (page 421)—pending the outcome of the recommended further study by the Hospital Association and The Medical Society of New Jersey to evolve a method for payment of outpatient service in the hospital department by the Medical-Surgical Plan of New Jersey.

Amended twice; adopted as amended

1st Amendment—Add to end of paragraph:
Any action taken must be with the approval of a regular or special meeting of the House of Delegates.

Adopted (split vote)

2nd Amendment—Add at beginning of paragraph:
In view of the immediate previous action of the House of Delegates, which provides a basis for the continuation of diagnostic services in the private office or in the outpatient department of a hospital, and since this previous action provides a basis for further enlargement of such benefits, then this committee . . .

Adopted

10. The committee gave a majority vote to disapprove *Resolution #3* (from Mercer County) (page 411) concerning *M.S.P. Apportionment of Fees*. It was the committee's feeling that the apportionment of fees which this resolution opposed should be continued.

Adopted

11. The committee voted to approve *Resolution #7* (from Hudson County) (page 414) on *M.S.P. Apportionment of Fees* by a majority vote. It was the feeling of the committee again that the apportionment of fees should be maintained as is supported by this resolution.

Adopted

12. The committee voted unanimously to approve *Resolution #11* (page 417) for *Medical-Surgical Plan Payment to Dental Oral Surgeons* for normal procedures in oral surgery being performed in New Jersey hospitals by licensed dentists specializing in oral surgery.

It was felt that if the House of Delegates approves Resolution #11, this would give support to the Medical-Surgical Plan's procedures for obtaining permission from the State Banking and Insurance Commission to make these payments.

Adopted

13. The committee voted unanimously to reject *Resolution #16* from the Bergen County Medical Society (page 420) which urged Medical-Surgical Plan of New Jersey to offer for public sale all riders to their contracts now limited to group certificate holders, to the general public whether they are enrolled in groups or are individual subscribers.

The committee agrees in principle with the resolution submitted and when studies indicate it is actuarially sound to include the wider coverage, that it be reconsidered.

Adopted

14. The committee approved the action of the Board of Trustees on *Diagnostic Cystoscopies* (page 368).

Adopted

15. The report from the Board of Trustees on the *Medicare Program* (page 365) was approved as submitted. We commend them for a job well done.

Adopted

16. The annual report of *Medical Service Administration* (page 424) was approved as contained in the printed material given to the House of Delegates. We wish to commend them for a job well done.

Adopted

17. The committee unanimously approved the nominations for membership on the *Board of Governors of Medical Service Administration of New Jersey* for 1960-61 (page 373).

Adopted

Adopted as amended as a whole

Reference Committee "D"

William E. Bray, M.D., Chairman

The reference committee met at 11:00 a.m., Sunday, May 15, 1960, at Haddon Hall, with all members present. We are grateful for the assistance of the many doctors who came to the meeting and discussed our problems with us. We also had with us representatives from the American Mutual Liability Insurance Company, E. & W. Blanksteen, and Mr. Durgom of Hospital Service Plan of New Jersey. The opinions of the doctors and the representatives of the different insurance companies aided us in making our report.

1. The report of the *Committee on Medical Education* (page 386) was approved.

Adopted

2. The report of the *Physicians Placement Service* (page 410) was approved.

Adopted

3. The report on *Retirement Plan for Physicians* (page 366) was approved.

Adopted

4. A. The report of the *Committee on Medical Defense and Insurance* (page 384) was approved for its information, and the single recommendation made in the printed report was approved:

> "That the services of E. & W. Blanksteen be continued as the Society's official broker for its accident and health insurance plan, and for its life insurance plan."

Adopted

B. The first recommendation in the supplemental report of the Committee on Medical Defense and Insurance (page 385) was disapproved:

> "That Plan III for major medical (catastrophic) insurance for members, offered by the National Casualty Company through E. &. W. Blanksteen, be adopted by the House of Delegates."

It is suggested by the reference committee that this recommendation be returned to the Committee on Medical Defense and Insurance for further study for the following reasons:

a. There is a probable conflict with Blue Cross coverage;

b. Other plans were brought to the attention of the committee which presumably give better integrated coverage.

Adopted

The second recommendation in the supplemental report was disapproved without prejudice until the first recommendation is resolved.

Adopted

C. From the annual report of the committee, it was noted that: "Despite repeated requests for information on the Society's professional liability plan, neither the carrier, U.S. F. & G., nor its agent, Faulhaber & Heard, has supplied the necessary data for the preparation of this portion of the committee's annual report."

The recommendation in the supplemental report (under the heading "Professional Liability Insurance") that Faulhaber & Heard not again be designated as the Society's official agent for professional liability insurance was approved.

Adopted

5. The report on *Professional Liability Insurance* from the Board of Trustees (page 366) was approved. The supplemental report from the Board on this item was also approved:

> "That the Professional Liability Insurance and Loss Control Program offered by the American Mutual Liability Insurance Company be adopted by the House of Delegates."

In addition, the reference committee recommends that a libel and slander rider—as suggested by the American Mutual Liability Insurance representatives—be favorably considered for the membership.

Adopted

6. *Resolution* #6, from the Somerset County Medical Society (page 413) on *Major Medical Insurance* was approved.

> "Resolved, that The Medical Society of New Jersey explore the possibilities of initiating an insurance program to provide major medical coverage for the members of its component medical societies."

Adopted

7. *Resolution* #2, from the Bergen County Medical Society (page 411) on *Interns* was approved:

> "Resolved, that the American Medical Association, through its Council on Medical Education, be directed to re-evaluate the approved intern programs so that the available supply may be more equitably spread over all the approved hospitals with more regard to the number of patients to be cared for, and to the needs of the

hospitals, and their ability to train physicians in the arts of Medical Practice . . . "

Adopted

8. *Resolution* #5, from the Passaic County Medical Society (page 413) concerning *Interns* was disapproved as written because, first, the committee felt that the word "reduced" should be changed to "re-evaluated," and, secondly, because the resolution should be forwarded to the American Medical Association if it is to have any significance.

Resolution amended:

word "reduced" changed to "re-evaluated"; add: "and be it further resolved that this resolution be forwarded to the A.M.A."

Amendment adopted

No. 8 amended to read: "Approved resolution as amended"

Adopted as amended

Adopted as amended as a whole

Reference Committee "E"

Robert E. Verdon, M.D., Chairman

The reference committee has considered each of the items referred to it and desires to submit the following report. The committee's recommendations on each item will be considered separately, and I respectfully suggest that each item be acted upon before going to the next.

1. This committee has carefully reviewed the annual report of the *Council on Legislation* (page 395). This committee wishes to commend the Council on Legislation for the diligent manner in which it has protected the rights of the medical profession by vigorously opposing the passage of unfavorable legislation. It has also been active in the promotion of those items of legislation which were considered advantageous to the medical profession. Worthy of specific mention is the immediate and forceful opposition to A-556. The council has called specific attention to the value of the *Membership News Letter* which gave excellent coverage, not only to the legislative scene but also to the political philosophy attending the issues. The council further urges the members to not only study the relevant portions of the *News Letter*, but to translate them into action.

Adopted

2. Your reference committee next considered the annual report and supplemental reports of the *Council on Medical Services* (page 397). The reference committee is fully cognizant of the many ramifications involved in obtaining the information necessary for the preparation of the Relative Value Index. The committee is also aware of the unusual amount of time involved in the preparation and completion of the report. This committee wishes to commend the council for the manner in which it accomplished the duty assigned to it. The committee is aware of the importance and probable irrevocable nature of any positive decision which involves conceptual changes. After listening to considerable discussion on the various facets of the Relative Value Index, the committee is not convinced that the membership is sufficiently informed to come to a final decision at this time. This committee feels it would be in the best interests of The Medical Society of New Jersey to allow more time for the general membership to become sufficiently informed on the Relative Value Index. This committee respectfully recommends that this matter be referred to the component societies for study and determination of the wishes of their members; that the results of the foregoing be reported to the Board of Trustees by November 1, 1960; and that the Board of Trustees shall present the results to the next meeting of the House of Delegates, annual or special.

Adopted

3. The report of the Special *Committee on Industrial Health* (page 402) was approved.

Adopted

4. The committee next considered the report of the Special *Committee on Workmen's Compensation* (page 403). The reference committee recommends that this special committee is the proper committee to conduct a study concerning its first recommendation—evaluation of cardiac disability in compensation cases.

Adopted

5. Next considered was the report of the *Council on Public Relations* (page 401). The committee commends the council for the initiation and fulfillment of its projects. The committee particularly wishes to call attention to the excellent coverage of important matters in both the *Periodic News Letter* and the *Membership News Letter*.

Adopted

6. The committee next considered those portions of the report of the Board of Trustees which were assigned to this reference committee. The first item concerned *Intravenous Medications by Nurses* (page 368). The Board of Trustees is to be commended for its part in the successful resolving of this potential dangerous medical-legal situation.

Adopted

7. The progress report of the Board on *Medical-Legal Testimony* (page 368) was reviewed and accepted.

Adopted

8. Next considered was the Board's supplemental report on the *School Examination Law Amendment* (page 373). The discussors who appeared before the reference committee were unanimously in favor of this legislation. The committee notes and was impressed with the enthusiastic re-affirmation by one of the discussors. The reference committee recommends that the House of Delegates direct that the legislation be re-introduced.

Adopted

9. The committee noted with regret that the A.M.A. House of Delegates in 1959 defeated the New Jersey resolution favoring *Social Security for Physicians* (page 369).

Adopted

10. The committee next considered *Resolution* #13—from Mercer County concerning *Assembly Bill* 556 (page 418). The committee agrees that A-556 is not in the interests of the practicing physician, and further agrees that A-556 should be opposed. The committee feels that refusal to renew Medical-Surgical Plan contracts as participating physicians could mean the end of Medical-Surgical Plan, which possibly might be the hidden intent of A-556. The committee therefore recommends that Resolution #13 be not adopted.

Adopted

11. *Resolution* #18 was next considered—concerning *Assembly Bills* 556, 612, and 60 (page 421). The committee after discussing the resolution wishes to submit the following alternate resolution feeling that it better expresses the obvious intent of Resolution #18:

Whereas, with the introduction (etc.—same as 1st paragraph of original resolution)

Whereas, the Bergen County Medical Society is on record as opposing Assembly Bills 556, 612, and 60, and all similar legislation; therefore be it

Resolved, that The Medical Society of New Jersey continue to oppose these bills and any similar legislation which encroach on the free practice of medicine by non-medical groups or individuals.

Adopted

12. *Resolution* #4 was next considered—concerning *Social Security for Physicians* as submitted by Essex County (page 412). The committee recommends the adoption of this resolution.

Adopted (split vote, 146 to 36)

13. Two resolutions on *Technical Services by Non-Professional Personnel* [#12 from the Board of Trustees (page 417) and #14 from the Radiological Society of New Jersey (page 419)], were next considered. The Society's Legislative Analyst stated to the reference committee that the amendment to paragraph k as proposed by the Radiological Society in Resolution #14 is acceptable. In view of this the reference committee recommends that no action be taken on Resolution #12 and that Resolution #14 be adopted.

Referred to Board of Trustees for action, with power to act

14. The committee considered *Resolution* #17 —*Fund Raising Organizations* from the Bergen County Medical Society (page 420). The committee feels that this resolution has merit, but is of the opinion that the study called for is too extensive to be made at state level. Therefore, we recommend that the resolution be amended as follows: Substitute the words "American Medical Association" for "The Medical Society of New Jersey" wherever they appear, and substitute "June" for "May" in the last line of the resolution.

The committee recommends that the resolution be adopted as amended.

Adopted

15. Next considered was *Resolution* #20—*Judicial Committee/Council Records* from an Essex Delegate (page 422). The committee recommends the adoption of this resolution.

Adopted

Adopted as amended as a whole

Reference Committee "F"

Dorsett L. Spurgeon, M.D., Chairman

Reference Committee "F" met on May 15, 1960, at 11:00 a.m. with the full committee present, namely: Dr. Mary Bacon, Dr. Louis A. Amdur, Dr. Samuel J. Lloyd, Dr. George E. Barbour, and Dr. Dorsett L. Spurgeon, chairman.

The committee considered 18 reports and three resolutions. There were about 35 members present discussing the reports and active discussion developed.

1. The committee unanimously approved the report of the Administrative Council on *Public Health* (page 399) and the reports of its special committees, namely:

Cancer Control (page 403)
Child Health (page 404)
Chronically Ill and the Aging (page 405)
Conservation of Hearing and Speech (page 405)
Maternal and Infant Welfare (page 406)
Mental Health (page 407)
Rehabilitation (page 408)
Conservation of Vision with exception of the paragraph concerning Eye Care on a Funded Basis (page 406)

The committee encourages the *Cancer Committee* to continue its recommendation of establishing a cancer registry in each hospital.

The *Child Health Committee's* recommendations that the component societies foster meetings with local school administrators, physicians, etc., and that their reaffirmation of its endorsement of water fluoridation for prevention of dental caries were approved.

Adopted

2. The committee approved the report of the Special *Committee on Disaster Medical Services* (page 408) and commends the committee on its stand for the corrections it has recommended.

Adopted

3. The committee approved the report of the Special *Committee on Traffic Safety* (page 409) and urged the committee to push their relations with the Division of Motor Vehicles in the State.

The reference committee wishes to go on record to thank all the chairmen and members of all the above committees.

Adopted

4. *Resolution* #9 on *Aeromedical Evacuation Transport Services* (page 415) was unanimously approved by the committee, and we recommend the House of Delegates give its unanimous support to the resolution.

Adopted

5. *Resolution* #10 concerning *Health Officer* (page 416) was unanimously approved with changes in wording, as per a new submitted resolution: (changes in wording underlined)

> Whereas, traditionally, physicians duly admitted to practice medicine in the State of New Jersey, who have received the degree of doctor of medicine from an accredited and recognized college of medicine, have as such, been eligible to occupy the position of Health Officer; and . .

Adopted

6. The items in the report of the Board of Trustees were all unanimously approved:

A. Optometrists/Contact Lenses/Drugs (Page 370)
B. Director, Division of Mental Deficiency (page 370)
C. Administration of Public Medical Care (page 370)
D. Utilization of Hospital Facilities (page 370)
E. Staphylococcal Infections in Hospitals (page 371)

Adopted

7. The *Nurses Training* report from the Board of Trustees (page 371) was partially, but not fully, approved, and we recommend that it be referred back to the Medical-Hospital Liaison Committee for further study and clarification before its complete approval.

Adopted

8. The committee finds nothing unethical in the *Pilot Plan for Eye Care on a Funded Basis* as submitted by the Board of Trustees of The Medical Society of New Jersey (page 369) and believes it was correct in its approval of the plan in principle.

However, in view of the apparent widespread opposition to the proposed plan as noted by Resolution #8 submitted by Middlesex and Cumberland County Medical Societies (page 414) and as noted in various meetings of the specialty societies of those most intimately involved, also as noted by the divided vote at every level of approval within The Medical Society of New Jersey, the commit-

tee hereby recommends that there be further study of the proposal. The committee further recommends that the plan be published and circulated throughout the membership for detailed examination before any implementation is undertaken.

Minority Report

Reference Committee "F"

Dr. Bowers, Officers, and Board of Trustees of The Medical Society of New Jersey, members of the House of Delegates:

I am Doctor Bacon of Cumberland County, a member of Reference Committee "F". I should like to submit a minority report for that committee.

The minority agrees with the majority report in all action except in the matter of Eye Care on a Funded Basis and relevant Resolution #8.

The minority disapproves the pilot plan on a funded basis for medical eye care and approves Resolution #8 for the following reasons:

1. The New Jersey Academy of Ophthalmology and Otolaryngology on November 11, 1959, at a regular meeting opposed by overwhelming vote the pilot plan on a funded basis for medical eye care.
2. The Rowsley Room in which Reference Committee "F" met was filled with men who identified themselves as ophthalmologists, many of them chairmen of county Conservation of Vision committees. These men were there to protest the approval of the pilot plan—and asking that the Board of Trustees' approval of the plan be rescinded.

Because these physicians in number 1 and number 2 instances were those most affected by the proposed plan, the minority of Reference Committee "F" felt that approval of the plan over their protests was not democratically sound.

We therefore disapproved the pilot plan on a funded basis for medical eye care and approved Resolution #8.

Substitution of minority report for majority report —defeated

Majority report—adopted

9. The committee recommends approval of *Resolution #8—Eye Care on a Funded Basis*—as submitted by the Middlesex and Cumberland County Medical Societies (page 414) which rescinds the action of the Board of Trustees only if the House of Delegates feels that further study as recommended in this committee's action on the annual report of the Board of Trustees is impracticable.

Ruled out of order

The chairman of the committee wishes to thank the members of his committee for the long hours and diligent service they have given.

Adopted as a Whole

Reference Committee "G"

John L. Olpp, M.D., Chairman

Reference Committee "G" met on May 15, 1960 with the following members present: Charles W. Boozan, M.D., Louis K. Collins, M.D., E. Vernon Davis, M.D., Eugene H. Kain, M.D., and John L. Olpp, M.D., Chairman.

1. The committee considered and approved the annual report of the *Annual Meeting Committee* (page 379) and recommends that the 198th annual meeting be held at Haddon Hall, Atlantic City—Saturday-Wednesday, May 16-20, 1964. The committee wishes to re-emphasize that portion of the report relating to specialty societies which points out there must be no tendency to confuse or identify section programs of The Medical Society of New Jersey with programs offered by the specialty groups and calls attention to the following quotation:

"The section programs of the Annual Meeting of The Medical Society of New Jersey are arranged by and for our members, and all publicity in connection with the annual meeting program is handled by the Council on Public Relations."

Adopted

2. The report of the *Credentials Committee* (page 381) was approved as submitted.

Adopted

3. The *Scientific Exhibits Committee* report (page 380) was approved.

Adopted

4. The committee approved the report of the *Scientific Program Committee* (page 380) and expressed the hope that effective ways may be found to encourage and increase attendance at the scientific meetings.

Adopted

5. The report of the *Advisory Committee to the Woman's Auxiliary* (page 388) was approved. The committee was pleased to learn that over and above all the achievements reported the Auxiliary contributed $4,658.99 to American Medical Education Fund and $3,115.22 to the Medical Student Loan Fund of The Medical Society of New Jersey. Your committee commends the Auxiliary for its good work.

Adopted

6. There were no nominations made for *Honorary Membership* (page 384).

No action

7. The committee approved the following *nominations for Emeritus Membership* (page 423):

Bergen County

Charles D. Cropsey, Rutherford; age 90

Essex County

Charles A. Breitstadt, Newark; age 70
Joseph Chiarmida, Brooklyn, N. Y. (formerly Verona); age 69
Katharine B. Hahn, South Orange; age 62
George E. Kalter, Bradenton, Fla. (formerly Maplewood); age 68
Ralph W. Walton, Montclair; age 73

Morris County

Harold S. Hatch, Winter Park, Fla. (formerly Morristown); age 69

Ocean County

Robert Buermann, Lakewood; age 72

Somerset County

Theodore M. Silverman, Somerville; age 68

Union County

Stanton H. Davis, Cambridge, Md. (formerly Plainfield); age 66
William B. Fort, Pompano, Fla. (formerly Plainfield); age 67
William H. McCallion, Spring Lake (formerly Elizabeth); age 69
Grace M. Robertson, Plainfield; age 75
Stephen Steele, Woodstock, N. H. (formerly Linden); age 64
Frank A. Williams, Elizabeth; age 69

Adopted

8. Your committee approved *Resolution #15*, commending *Drs. Allman and Costello* (page 419) deservedly, for outstanding service to the Council on Medical Services of the American Medical Association. Your committee recommends adoption of the resolution.

Adopted

9. *Memorial to Samuel A. Cosgrove, M.D.* (page 422). Report amended to include memorial to Dr. Cosgrove.

Adopted

Report as amended adopted as a whole

Reference Committee on Constitution and Bylaws

Andrew C. Ruoff, III, M.D., Chairman

The reference committee met at 11:00 a.m., Sunday, May 15, 1960, with all members of the committee present: Dr. Ruoff, chairman; Dr. Eynon, Dr. Smith, Dr. Gleason and Dr. Zimmerman.

The following items were considered:

1. *Amendments to the Constitution*—(page 389) The proposed amendments to the Constitution previously approved by the House of Delegates at the 1959 Annual Meeting were reviewed and are presented for final vote:

Current

ARTICLE IV—ORGANIZATION OF THE SOCIETY

Section 2 — Fellows

The Fellows are the Past-Presidents of this Society.

Any member of this Society, not already a Fellow, who is elected President of the American Medical Association, shall at the completion of his term, become a Fellow of this Society.

Proposed

ARTICLE IV—ORGANIZATION OF THE SOCIETY

Section 2 — Fellows

Add the following footnote:

(The "immediate past-president" is that living past-president between whom and the presidency no succeeding living past-president intervenes.)

Adopted

Section 4 — Delegates

(a) Apportionment and Election. Each component society shall be entitled to one (1) delegate for each fifteen (15) members or major fraction thereof, to be elected at any meeting prior to March 31 of the fiscal year by a majority ballot of the members present. Each delegate shall be elected for three (3) years. Each component society shall be entitled to at least three (3) delegates.

Section 4 — Delegates

(a) Apportionment and Election. Each component society shall be entitled to one (1) delegate for each fifteen (15) members or major fraction thereof, to be elected at any meeting prior to March 31 by a majority ballot of the members present. The term of office of each delegate shall be for three (3) administrative years and shall begin on April first next following his election. Each component society shall be entitled to at least three (3) delegates.

Adopted

ARTICLE IX — OFFICERS

Section 2 — Election

The Officers shall be elected by ballot at the second session of the House of Delegates at the annual meeting. No member shall be eligible for more than one (1) office at the same time, except the President, the President-Elect, the First and Second Vice-Presidents, the Secretary, and the Treasurer, who by virtue of such offices are at the same time members of the Board of Trustees. A vacancy in office occurring between annual meetings may be filled by the Board of Trustees until the next regular election.

ARTICLE IX — OFFICERS

Section 2 — Election

The Officers shall be elected by ballot at the second session of the House of Delegates at the annual meeting. No member shall be eligible for more than one (1) office at the same time, except the President, the President-Elect, the First and Second Vice-Presidents, the Secretary, and the Treasurer, who by virtue of such offices are at the same time members of the Board of Trustees. A vacancy in office, except that of the President-Elect, occurring between annual meetings may be filled by the Board of Trustees until the next regular election.

Adopted

ARTICLE XII—AMENDMENTS TO THE CONSTITUTION

A. Procedure for First Year

1. Submission of the proposed amendment in writing through the Secretary of this Society, to the Standing Committee on Revision of Constitution and Bylaws and to each component society by the Board of Trustees, the Judicial Council, or a component society, at least three (3) months before the annual meeting.

ARTICLE XII—AMENDMENTS TO THE CONSTITUTION

A. Procedure for First Year

1. Submission in writing of an amendment proposed by the Board of Trustees, by the Judicial Council, or by a component society to the Secretary of this Society not later than February first.

2. Transmission by the Secretary of the proposed amendment to the Standing Committee on Revision of Constitution and Bylaws and to each component society not later than February 15.

(Renumber balance—paragraph 2 becomes 3, etc., ending with paragraph 10 becoming 11.)

Adopted

2. *Amendments* to the Constitution and Bylaws *from the Union County Medical Society* (page 391) were recommended for adoption by the House of Delegates, with the changes as recommended by the committee on the Revision of Constitution and Bylaws. Your reference committee revised the method of proration with the *recommendation* that there be one (1) elected Trustee from each component society on the basis of 500 members and major fraction thereof, and *recommended* the appropriate wording to be incorporated under Section 1, Composition, by deleting the word "or" and substituting the words "and major."

UNION COUNTY PROPOSALS

CONSTITUTION — ARTICLE VI — BOARD OF TRUSTEES

Section 1 — Composition

The Board of Trustees shall be the executive body. It shall be composed of the Immediate Past-President, President, President-Elect, two (2) Vice-Presidents, Secretary, and Treasurer (by virtue of their offices), and elected Trustees. Each County society shall be entitled to at least one (1) Trustee and for the larger counties they shall be entitled to one (1) Trustee for each five hundred (500) active or voting members or fraction thereof as of December 31 of each year. Each Trustee shall be elected from and by his component county society prior to the annual meeting of the House of Delegates. The term of office shall be three (3) years and such term shall commence upon the expiration of the term of the former incumbent. The term of office of one third (1/3) of the elected Trustees shall terminate annually.

Section 2 — Procedure

Provided that at the first election following the adoption of these amendments, the first seven (7) counties alphabetically, from Atlantic through Essex, shall elect one Trustee from each county for one year, the second seven (7) counties, from Gloucester through Morris, shall elect one (1) Trustee from each county for two (2) years, and the third seven (7) counties, from Ocean through Warren, shall elect one Trustee from each county for three years. Counties with more than one (1) Trustee shall elect them on a staggered basis, for one (1), two (2), and three (3) years. Thereafter at the expiration of these terms each Trustee shall be elected for a full term of three (3) years.

REFERENCE COMMITTEE RECOMMENDATIONS

CONSTITUTION — ARTICLE VI — BOARD OF TRUSTEES

Section 1 — Composition

The Board of Trustees shall be the executive body. It shall be composed of the Immediate Past-President, President, President-Elect, two (2) Vice-Presidents, Secretary, and Treasurer (by virtue of their offices), and elected Trustees. Each component society shall be entitled to one (1) elected Trustee.

The larger component societies shall be entitled to one (1) elected Trustees for each five hundred (500) members and major fraction thereof as of December 31 of each year. Trustees shall be elected from and by component societies prior to the proper annual meeting of the House of Delegates. The term of office shall be three (3) years (subject to the maintenance of membership totals under proration) and such term shall commence upon the expiration of the term of the incumbent. The tenure of office of approximately one-third (1/3) of the elected Trustees shall terminate annually.

Defeated (Split vote, 82 to 106)

Section 2 — Procedure

Following the adoption of these amendments incumbent Trustees shall serve out their elected terms as representatives of the component societies in which they hold membership. Remaining and succeeding Trustees shall be elected by component societies the year following the adoption of these amendments for one (1), two (2), or three (3) year terms—to equalize the process.

Out by defeat of Section 1

Section 3 — Term of Office

Any member as classified in Article VI, Section 1, may be elected a Trustee for a maximum of three (3) full terms provided however that if the first two (2) elected terms are successive there shall be a lapse of at least one (1) year between expiration of the second (2) and commencement of the third (3) term.

Section 3 — Term of Office

Any member may be elected a Trustee for a maximum of three (3) full terms.

Approved for final consideration in 1961

Section 4 — Filling Vacancies

In the event that the office of any member becomes vacant for any reason the component county society wherein the vacancy exists shall elect a member within ninety (90) days to fill the unexpired term.

Section 4 — Filling Vacancies

In the event that the office of any elected Trustee becomes vacant the component society wherein the vacancy occurs shall elect a successor within ninety (90) days, to fill the unexpired term.

Out by defeat of Section 1

---

3. *Resolution #1—Representation in the House of Delegates*—from the Bergen County Medical Society (page 410) was reviewed by the reference committee and is recommended to the House of Delegates for approval.

Note: (at present, there are 416 delegates, and adoption of this method of representation would at present reduce the House of Delegates to 313).

Adopted for referral to and action by the Committee on Revision of Constitution and Bylaws

4. The reference committee accepted the report of the *Committee on Revision of Constitution and Bylaws* (page 393) and unanimously commended Dr. Albright and his committee for the excellent work done.

Adopted

Report as amended adopted as a whole

REPORT OF THE NOMINATING COMMITTEE AND ELECTION

(May 15, 1960)

Office	*Term*	*From*	*To*	*Nominee*
President-Elect	1 year	May 1960	May 1961	Ralph M. L. Buchanan, Warren County
1st Vice-President	1 year	May 1960	May 1961	Louis S. Wegryn, Union County
2nd Vice-President	1 year	May 1960	May 1961	Carl N. Ware, Cumberland County
Secretary	1 year	May 1960	May 1961	Marcus H. Greifinger, Essex County
Treasurer	1 year	May 1960	May 1961	Daniel F. Featherston, Monmouth County
Trustees:				
2nd District	3 years	May 1960	May 1963	John J. Bedrick, Hudson County
3rd District	3 years	May 1960	May 1963	Samuel J. Lloyd, Mercer County
4th District	3 years	May 1960	May 1963	Frank J. Hughes, Camden County
5th District	1 year	May 1960	May 1961	Louis K. Collins, Gloucester County
(Unexpired term of Dr. Ware, elected Second Vice-President)				
11th Trustee	3 years	May 1960	May 1963	Joseph R. Jehl, Passaic County

Judicial Councilors:				
1st District	3 years	May 1960	May 1963	Emanuel M. Satulsky, Union County
4th District	3 years	May 1960	May 1963	E. Vernon Davis, Burlington County
A.M.A. Delegates:				
	2 years	Jan. 1961	Dec. 1962	C. Byron Blaisdell, Monmouth County
	2 years	Jan. 1961	Dec. 1962	Joseph P. Donnelly, Hudson County
	2 years	Jan. 1961	Dec. 1962	Marcus H. Greifinger, Essex County
	2 years	Jan. 1961	Dec. 1962	L. Samuel Sica, Mercer County
A.M.A. Alternates:				
	2 years	Jan. 1961	Dec. 1962	Robert N. Bowen, Camden County
	2 years	Jan. 1961	Dec. 1962	F. Clyde Bowers, Morris County
	2 years	Jan. 1961	Dec. 1962	John F. Kustrup, Mercer County
	2 years	Jan. 1961	Dec. 1962	Joseph R. Jehl, Passaic County
	1 year	Jan. 1961	Dec. 1961	John L. Olpp, Bergen County
		(Unexpired term of Dr. Donnelly, resigned)		
Delegates and Alternates to Other States:				
New York:				
Delegate	1 year	For 1961 Convention		William F. Costello, Morris County
Alternate	1 year	For 1961 Convention		Levi M. Walker, Atlantic County
Connecticut:				
Delegate	1 year	For 1961 Convention		Lloyd A. Hamilton, Hunterdon County
Alternate	1 year	For 1961 Convention		S. Eugene Dalton, Atlantic County
Administrative Councils:				
Legislation:				
1st District	2 years	May 1960	May 1962	Ludwig L. Simon, Essex County
2nd District	3 years	May 1960	May 1963	Winton H. Johnson, Bergen County
3rd District	1 year	May 1960	May 1961	Leonard Rosenfeld, Hunterdon County
4th District	2 years	May 1960	May 1962	William E. Bray, Burlington County
5th District	3 years	May 1960	May 1963	John S. Madara, Salem County
6th Member	1 year	May 1960	May 1961	Sigmund C. Braunstein, Hudson County
Medical Services:				
1st District	2 years	May 1960	May 1962	Francis J. Benz, Morris County
2nd District	3 years	May 1960	May 1963	Louis A. Amdur, Hudson County
3rd District	1 year	May 1960	May 1961	Durant K. Charleroy, Mercer County
4th District	2 years	May 1960	May 1962	Frederick W. Durham, Camden County
5th District	3 years	May 1960	May 1963	Charles B. Norton, Jr., Salem County
6th Member	1 year	May 1960	May 1961	Donald B. Hull, Bergen County
Public Health:				
1st District	2 years	May 1960	May 1962	Estelle T. Milliser, Union County
2nd District	3 years	May 1960	May 1963	John P. Coughlin, Hudson County
3rd District	1 year	May 1960	May 1961	Elmer J. Elias, Mercer County
4th District	2 years	May 1960	May 1962	Authony P. DeSpirito, Monmouth County
5th District	3 years	May 1960	May 1963	Gene N. Schraeder, Atlantic County
6th Member	1 year	May 1960	May 1961	Pascal J. Baiocchi, Essex County

Public Relations:						
1st District	2 years	May	1960	May	1962	S. William Kalb, Essex County
2nd District	3 years	May	1960	May	1963	Robert A. Weinstein, Sussex County
3rd District	1 year	May	1960	May	1961	Gerard R. Gessner, Middlesex County
4th District	2 years	May	1960	May	1962	Howard C. Pieper, Monmouth County
5th District	3 years	May	1960	May	1963	Paul H. Steel, Atlantic County
6th Member	1 year	May	1960	May	1961	William P. Mulford, Burlington County
Standing Committees:						
Annual Meeting:						
	1 year	May	1960	May	1961	Peter H. Marvel, Atlantic County
	2 years	May	1960	May	1962	Raymond J. Gadek, Middlesex County
	3 years	May	1960	May	1963	Herschel S. Murphy, Union County
Finance and Budget:						
	1 year	May	1960	May	1961	Francis A. Hauck, Cape May County
	2 years	May	1960	May	1962	Conrad M. Bahnson, Hudson County
	3 years	May	1960	May	1963	Theodore K. Graham, Passaic County
Medical Defense and Insurance:						
	1 year	May	1960	May	1961	Daniel F. Featherson, Monmouth County
	2 years	May	1960	May	1962	William L. Palazzo, Bergen County
	3 years	May	1960	May	1963	Ernest C. Hillman, Jr., Essex County
Medical Education:						
	1 year	May	1960	May	1961	Malcolm M. Dunham, Middlesex County
	2 years	May	1960	May	1962	Frank S. Forte, Essex County
	3 years	May	1960	May	1963	Louis F. Albright, Monmouth County
Publication:						
	1 year	May	1960	May	1961	C. Spencer Davison, Salem County
	2 years	May	1960	May	1962	Fred B. Rogers, Mercer County
	3 years	May	1960	May	1963	Joseph E. Mott, Passaic County
Woman's Auxiliary:						
	1 year	May	1960	May	1961	A. Guy Campo, Gloucester County
	2 years	May	1960	May	1962	Ralph K. Bush, Camden County
	3 years	May	1960	May	1963	George O. Rowohlt, Bergen County

Upon motions duly made, seconded, and carried, all nominees were elected to the designated offices and for the terms indicated.

President's Address*

F. Clyde Bowers, M.D., Mendham

It is usually customary for a retiring president to summarize the accomplishments of his administration. Since a review of the past year's efforts has already been submitted in my Annual Report, I am going to take advantage of this opportunity to propose some innovations in our State Society. My tours about the State, making contacts with many people both within and outside our organization, have suggested some ideas for strengthening our Society. Similar actions taken in other State Societies convince me all the more that we in New Jersey should likewise attempt to improve our lot. Recognizing that making any proposals for the future at this particular time may appear as an attempt to usurp the prerogative of the new administration, I have taken the precaution to clear these suggestions with our new president. He agrees that these thoughts should be given serious consideration in the coming months, and that some are even now ready for implementation.

I wish to talk to you about a subject which we, as physicians, have sometimes tried to shun as beneath our dignity or unworthy of our deliberation or wholly unnecessary for our consideration. Yet non-medical people, especially organized labor, have given this matter top priority and it has received headline billing in recent years. I speak of medical economics—not as it affects the income of the physician, but as it affects the pocket-book of the consumer.

In approaching this problem I reiterate what I suggested a year ago, namely that we do some positive thinking and take to the offense rather than continuously to fight a defensive battle. To this end then, I suggest that we evaluate and list our assets and virtues. It is surprising to find how little the public knows about us—the number of free services, our emergency call system, our judicial mechanism, our grievance committee, our self-policing in hospitals (committee on admissions and discharges, tissue committees, auditing committees), our code of ethics. Many do not realize the number of hours of professional service donated by doctors on the wards and in the clinics of our hospitals, the many indigents seen at home and in our offices without compensation. Nor do they know that no one is ever denied necessary medical care because of his inability to pay. These and many other services both we and the public have always taken for granted. Lest—in their zeal to combat the increased cost of medical care by whatever means possible—the public forget, let us remind them.

At the same time we are not entirely guiltless in relation to this rise in cost of medical care. Let us, then, at the same time that we proclaim our attributes, recognize and correct our weaknesses. We must be willing to put our own house in order. There are some few among us who cannot rightfully lay claim to innocence in respect to certain abuses, especially when there is insurance coverage. In this regard, it might be helpful if the Society would appoint a committee to review and settle disputes between physician and patient when Blue Cross or Blue Shield is involved. Of course, these service corporations as well as the physician, by prior agreement, must be willing to accept the decision of this committee.

As free citizens, as well as physicians, we should display a greater willingness to speak out forthrightly in public for our ideals. As the last great bulwark of defense against a socialistic government, we should enlist the help of all who are dedicated to preserving a free democracy. To strengthen our position we should attempt better liaison and maintain good rapport with paramedical and other professional groups. We should be encouraged by and should give encouragement to the United States Chamber of Commerce for its current stand against the socialistic trends in Congress.

In considering the medical care of the indigent in New Jersey, we should study the recommendations of the Governor's Special Commission to study the Administration of Public Medical Care. Since we have already approved these recommendations in principle we should now set up a program for activation before the State Government does it for us. Your new administration has already considered this problem and will assign a proper committee soon. However, all of us should study this program and offer to help our president in every way possible.

I should like to make one more proposal which is to repeat the suggestion made a year ago. At that time I stated that we might solve many of our problems if we would sit down with all parties interested in medical care—especially representatives from Blue Cross, Blue Shield, Commercial Insurance Companies,

*House of Delegates, May 14, 1960.

Hospital Associations and Labor—and have an open discussion on total medical care. Although there were many who agreed with this proposal, there were some lukewarm and others who felt that such an effort would be fruitless. However, since that time—within the past year—similar committees have been established in two states and as of today (May 14th) there is a meeting being held involving representatives of these groups and representatives of the American Medical Association. Therefore, I am more convinced than ever that a similar effort should be made at our state level. Thus far our Board of Trustees has authorized the establishment of such a committee, and we have had an expression of willingness on the part of certain representatives of organized labor to participate. I hope that in the near future the other principals mentioned above will agree to such a discussion.

In closing, I exhort you to support our president and his administration. Offer your services whenever possible and fulfill all assignments. Let us not show any weakness by division in our ranks, but rather let us proclaim our strength by unity of organization. Let us show that we are dedicated to the welfare of our people, but are opposed to the welfare state.

Special Action by Delegates

1959 TRANSACTIONS

At its first session on Saturday afternoon, May 14, 1960, the House of Delegates approved:

The Transactions of the 1959 House of Delegates as published in the July, 1959 JOURNAL and distributed to the membership.

when you see signs of **anxiety-tension** specify

Dartal®

dihydrochloride

brand of thiopropazate dihydrochloride

for rapid relief of anxiety manifestations

You will find Dartal outstandingly beneficial in management of the anxiety-tension states so frequent in hypertensive or menopausal patients. And Dartal is particularly useful in the treatment of anxiety associated with cardiovascular or gastrointestinal disease, or the tension experienced by the obese patient on restricted diet. You can expect consistent results with Dartal in general office practice.

with low dosage: Only one 2, 5 or 10 mg. tablet t.i.d. *with relative safety:* Evidence indicates Dartal is not icterogenic.

Clinical reports on Dartal: 1. Edisen, C. B., and Samuels, A. S.: A.M.A. Arch. Neurol. & Psychiat. *80*:481 (Oct.) 1958. 2. Ferrand, P. T.: Minnesota Med. *41*:853 (Dec.) 1958. 3. Mathews, F. P.: Am. J. Psychiat. *114*:1034 (May) 1958.

SEARLE

The Children's Country Home

An accredited 54-bed specialized hospital for handicapped children. Especially equipped for care of cardiac pre- and postoperative cases, cerebral palsy, polio, congenital defects, rheumatoid arthritis, Legg-Perthes' diseases and other orthopedic conditions. Our services include physical therapy and pool treatments, x-ray, occupational and speech therapy. Regular schooling is provided.
The referring physician may continue to prescribe treatment or may transfer responsibility to our staff.

* * *

New Providence Road
Westfield, New Jersey

HILLTOP

PRIVATE NURSING HOME, INC.

Kings Highway • Middletown, N. J.

Catering to the post-operative patient, the convalescent, the cardiac, vascular and renal patients, fracture and castastrophic cases, as well as the long-term chronically ill and the geriatric patient.

Joseph H. Meyer - Administrator

OSborne 1-0177

BEL AIR MANOR NURSING HOME

JOHN FIORILLA, Managing Director
14 LEONARD PLACE — Cor. 5th Avenue
HASKELL, N. J. **TEmple 9-1010**

Ivy Hall Licensed Nursing Home

CARDIACS - INVALIDS - CONVALESCENTS - CHRONIC-AGED - DIABETICS - OBESITY
PARK ENTRANCE, BRIDGETON, NEW JERSEY
Benjamin Berkowitz, M.D., Medical Director Phone: GL. 1-2990

THE TRAINING SCHOOL
at VINELAND, NEW JERSEY
FOR THE MENTALLY RETARDED CHILD

Established in 1888, the Training School accepts boys and girls 2 years and up with mental potential of 6 years. Individually planned training, treatment in useful, happy atmosphere. Cottage living. School, hospital, lake, pools, farm, all therapies, medical-professional services. Nine-week summer program. Internationally-known research center.
Write Registrar, Box 2, THE TRAINING SCHOOL at VINELAND, NEW JERSEY

BS

BANCROFT SCHOOL

Specialized individual training for the retarded and emotionally unstable child. All school subjects and advantages. Recreation, sports, social training, understanding home life. Medical and psychiatric supervision. Recently constructed fireproof dormitories. Nonprofit education foundation. Founded 1883. *For booklet and information, address*

J. C. COOLEY, Principal
Box 119, Haddonfield, N. J.

FAIR OAKS

SUMMIT, NEW JERSEY

An 80 bed private psychiatric hospital for intensive treatment specializing in the latest therapeutic techniques plus electroshock and insulin coma therapy. Write

THOMAS P. PROUT, Jr.
Administrator

OSCAR ROZETT, M.D.
Medical Director

P. SINGER, M.D.
E. SOKAL, M.D.
ELIZABETH ROZSA, M.D.
M. E. NEUMAN, M.D.
Associates

Tel. CRestview 7-0143

The Glenwood Sanitarium

LICENSED FOR THE CARE AND TREATMENT OF

NERVOUS AND MENTAL DISORDERS
ALCOHOLISM AND DRUG ADDICTION

Homelike surroundings, good nursing psychiatric treatment, including shock therapy and excellent food.

R. GRANT BARRY, M.D.

2301 NOTTINGHAM WAY TRENTON, N. J.
JUniper 7-1210

OCEAN VIEW
Nursing Home

301 ATLANTIC AVENUE

Atlantic City, New Jersey

HALL-BROOKE HOSPITAL

An Active Treatment Hospital, located one hour from New York

Accredited by: The Central Inspection Board of the American Psychiatric Association
The Joint Commission on Accreditation of Hospitals

HALL-BROOKE, GREENS FARMS, BOX 31, CONN.

Telephone: WESTPORT CAPITAL 7-1251

George S. Hughes, M.D.
Leo H. Berman, M.D.
Albert M. Moss, M.D.
Louis J. Micheels, M.D.
Robert Isenman, M.D.
John D. Marshall, Jr., M.D.
Edward M. Keelan, M.D.
Peter P. Barbara, Ph.D.

The EVANS HOME for THE AGED

* * *

ISLAND HEIGHTS, NEW JERSEY
TEL. CH. 4-9216

REV. WILLIAM J. EVANS, Owner and Operator

M. Elizabeth Cheatham

LICENSED BOARDING HOME FOR ELDERLY

Personal Supervision, Maid & Tray Service, Companionship, Large Porch - $100.00 month up.
520 CENTRAL AVENUE PLAINFIELD, NEW JERSEY
Phone — PLAINFIELD 7-3579

ALLEN'S NURSING HOME

Leesburg **New Jersey**

SPECIALIZING IN CARE AND TREATMENT OF
Convalescents and Chronic Illnesses
Licensed by State of New Jersey

AMITY NURSING HOME

Ringoes, N. J.

●

Professional Nursing Care to the Aged and Chronically Ill

Mrs. K. Heck
Miss R. Reedy Flemington 1452-J4

MRS. MARY J. BALL

BOARDING HOME FOR THE AGED

14 SO. BURNETT STREET ORange 3-4305 EAST ORANGE, N. J.

THE MARSH HOUSE

East Orange - New Jersey

Comfortable living in pleasing surroundings for ambulatory ladies and gentlemen who need considerate care and attention by trained personnel.

Inspection and Inquiry by Members of The Medical Society of New Jersey are Cordially Invited.

Holmdel NURSING HOME

FOR THE AGED, CONVALESCENT AND CHRONICALLY ILL

STATE HIGHWAY No. 34
HOLMDEL, N. J.
WHitney 6-4142

The Golden Age REST HOME

FOR SENIOR CITIZENS

Male and Female— 24 Hour Care Registered Nurse — Dining Room or Tray Service — Recreational and Occupational Facilities.

21 HUDSON STREET
FREEHOLD, N. J.
FReehold 8-0567

— Reasonable Rates —

OWNERSHIP-MANAGEMENT of GEORGE CUCHURAL and CONSULA CUCHURAL, R.N.

Both Homes Approved by State Department of Institutions and Agencies

SYLVAN NURSING HOME

- Nervous Disorders
- Shock Treatments
- Chronic Patients

BOX 146
Grand Avenue and Trenton Avenue
WEST TRENTON, NEW JERSEY
Telephone TUxedo 2-0236

MARTA VOL-TRETTER, M.D.
Medical Director

ELEONORE LaCOUR, R.N.
Superintendent

PIlgrim 3-3424

ROEMER House

NURSING and CONVALESCENT HOME

157 THOMAS STREET
BLOOMFIELD, NEW JERSEY
PIlgrim 3-3424

M. C. Eingrieber, R.N. - Director

HANCOCK POOLS

SIGN UP TODAY TO INSURE QUICK DELIVERY OF YOUR POOL

- **Steel Reinforced**
- **Concrete Construction**

BANK FINANCING
NO DOWN PAYMENT
5 YEARS TO PAY

- 5 Years Guarantee on Workmanship
- 3 Years Written Guarantee on Magna-Bond Coating.

CALL OR WRITE —

R. E. HANCOCK
Tel. STATE 2-2480
R.D. No. 2, FLEMINGTON, N. J.

The Poconos' Famous Cottage Resort

Sky Lake Lodge and 50 individual cozy cottages high on a beautiful mountain lake. (Alt. 1600 ft.) Naturally wooded setting. Activities for all ages; swimming, sailing, water skiing, fishing, entertainment. Famous for fine food

Write for color booklet or phone Hawley 4596.

LEN-A-PE VILLAGE

Tafton, Pike Co., Pa. *in the Poconos*

Custom - Built

SWIMMING POOLS

CALL CRESTVIEW 7-3118 FOR FREE ESTIMATE (No Obligation, of Course)
Sunday Calls Accepted

Order Now and Save - In Time for Summer Fun!

BEAUTIFUL MARBLEIZED FINISH

HI-DENSITY POURED CONCRETE CONSTRUCTION

- **Any Size**
- **Any Shape**
- **Custom-Built for You**

POOLS OF DISTINCTION
for
MEN OF DISTINCTION

CLIP AND MAIL
CINDY POOLS, INC.
1029 Mountain Ave.
Berkeley Heights, N. J.
Gentlemen: Please send free brochure
Name
Address
City Phone

CINDY POOLS, Inc.
"Pools of Distinction"

Affiliated with DiNizo Bros.

1029 Mountain Ave. Berkeley Heights

CRestview 7-3118

Silver Bay Point

ON BEAUTIFUL BARNEGAT BAY

OFF ROUTE 549, SILVERTON, TOMS RIVER, N. J.

For rest, relaxation and comfort — you'll find the Summer home you want at this Barnegat Bay community. Schools, Shopping Centers, Churches, Country Clubs, Shore Resorts — only minutes away!

City Water

- Boating
- Fishing
- Swimming
- Hunting

PROPERTIES ON:

• LAGOON • BAYFRONT • WOODLAND

- Fire Protection
- Refuse Collection
- All Utilities

Silver Bay Point

Silverton, Toms River, N. J. Dlamond 9-3669

IN NORTH JERSEY

PHONE: SWARTHMORE 6-4500 • MARKET 2-0400

Write for Directions From your home and brochure

Directions . . .
Southbound: Garden State Parkway Exit 91 and Route 549
Northbound: Garden State Pky. Exit 82 and Routes 37 & 549

Some homes now ready for immediate occupancy

Deer Chase Manor

TOMS RIVER • NEW JERSEY

FOR SALE—3 Bedroom Ranch Colonial House. 2 Baths - 2 Car Garage - Full Cellar. Fireplace, 9/10 Acre Valuable Land. Corner Pineview Drive. 200 Feet frontage Route 37 near Community Hospital - Restricted beautiful neighborhood. Ideal for professional. 30 yr. FHA Mtge.
Price $28,000 - Terms - Immediate possession. Phone Dlamond 9-1975 - Eve. Dlamond 9-4396.
Deer Chase Manor, Inc., Owners Office at Ye Olde Cedar Inn.

Protection against loss of income from accident and sickness as well as hospital expense benefits for you and all your eligible dependents.

THE CRANE PLAN is the fruit of 30 years experience and research in billing and collecting current and past due accounts for members of The Medical Society of New Jersey.

CRANE DISCOUNT CORP.
Executive Offices
221 WEST 41st STREET
NEW YORK 36, N. Y.

ALL PREMIUMS COME FROM — PHYSICIANS SURGEONS DENTISTS — ALL BENEFITS GO TO

PHYSICIANS CASUALTY & HEALTH ASSOCIATIONS

OMAHA 31, NEBRASKA

Since 1902

Handsome Professional Appointment Book sent to you FREE upon request.

RETIREMENT FUNDS FOR DOCTORS AT STATE and COUNTY LEVELS

FREE OFFER

You may have read in the medical press that Standard & Poor's confidential questionnaire showed 82 per cent of the Nation's doctors want to join together in some type of retirement fund with the money invested in common stocks and/or bonds.

Significantly:

A majority of the responding doctors said they prefer that such retirement funds be established and administered by **county societies** or **state associations.**

Some of these medical groups already are going ahead with the assistance of Standard & Poor's. For **free** information on how county societies and state associations can easily establish retirement funds for their doctor members, write to Gerard Tonachel at

Standard & Poor's Corporation

WORLD'S LARGEST STATISTICAL AND INVESTMENT ORGANIZATION

345 HUDSON STREET NEW YORK 14, N. Y.

A-654

To: ***The busy man who buys and watches his own investments . . .***

You are busy at running your business or profession and you are a master at that job. You have capital to invest because you are a master at your own business or profession. Many busy, successful men have put their investment dollars in Mutual Funds, knowing that many of their own hours will be spared while busy professional investment managers do the watching and the decision-making for them.

Send for free details on Mutual Fund investing.

LOUIS R. DREYLING & CO.

181 GATZMER AVE. JAMESBURG, N. J.

Phone JA. 1-0441

NAME .....

ADDRESS .....

Please send me FREE details on Mutual Fund investing.

For Free Prospectus Address—

HUGH W. LONG AND COMPANY, INC.

Elizabeth 3, N. J.

IMPORTANT ANNOUNCEMENT . . .

TO ALL **THERMOFAX** OWNERS

PAUL B. WILLIAMS, Inc. has been named exclusive distributors for a new quality paper for Thermofax machines. It's called CALOCOP—a WHITE copy paper at a great saving over your present copy paper.

CALOCOP will not turn dark from sunlight, radiator heat or prolonged storage. Another advantage of WHITE CALOCOP copy paper is its resistance to tearing down from heavy usage. Continuous field tests have proven the superiority of CALOCOP.

WRITE, wire or phone for samples to Paul B. Williams, Inc., located at 1010 Broad Street in Newark, New Jersey—phone Mitchell 2-6464 in New Jersey, or Worth 4-3447 in New York City—or any of the other Paul B. Williams, Inc. branch offices in Chicago, Ill., Trenton, N. J., Cambridge, Mass., White Plains, N. Y., Greensboro, N. C., Charlotte, N. C. Paul B. Williams, Inc. is one of the country's largest distributors of KODAK Verifax machines and have attained national prominence in this field. Solving copying problems and prompt, efficient service on all copying machines have been the keystone of their success. Call **Paul B. Williams, Inc. — today.**

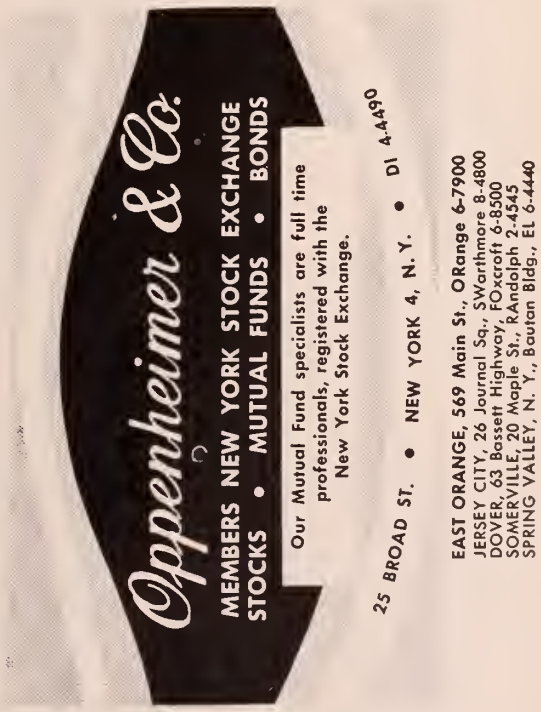
EVER CONSIDER MICROFILMING

- **ELECTROENCEPHALOGRAMS ?**
- **RADIOGRAPHS ?**
- **CARDIOGRAPHS ?**
- **MEDICAL RECORDS ?**

COST—MODEST
QUALITY—SUPERB
Write for Samples, Costs, Etc.
Without Obligation

MICROFILMING CORPORATION OF AMERICA
2 LLEWELLYN AVE. HAWTHORNE, N. J.
HAwthorne 7-7894 - 7895

Authorized Recordak Dealer



ROMA SAVINGS AND LOAN ASS'N.

249 HAMILTON AVENUE

Trenton 10, New Jersey

INSURED SAVINGS

"How to Take a Fortune out of Wall Street"

By J. A. LEMPENAU

This NEW book will amaze you — it may change your entire life!

Here, revealed for the first time, are the little-known methods used successfully by the author to build his estate over the past 35 years. All phases of market operations are fully explained. Page after page illustrates how to avoid common pitfalls.

BONUS OFFER — As an inducement for your prompt action, an important bulletin giving "Best Buys" and answering "What Action Now?" will be included at no extra cost. For your copy of this eye-opening book **plus** the bonus bulletin, send $3 today to:

THE INCOME BUILDER
RIVER EDGE • NEW JERSEY

THE OLDEST COMMERCIAL BANK IN HUDSON COUNTY

• • •

Offers
COMPLETE BANKING
AND TRUST SERVICES

• • •

HUDSON COUNTY NATIONAL BANK

1851 — OUR SECOND CENTURY OF BANKING — 1960

EIGHT OFFICES SERVING HUDSON COUNTY

Jersey City - Bayonne - Hoboken - Guttenberg

Member
Federal Reserve System
Federal Deposit Insurance Corporation

"GROW WITH US"

THE FIRST NATIONAL BANK OF MARLTON

MARLTON, NEW JERSEY

Member of F.I.D.C.

MOORE'S HOME FOR FUNERALS

384 Totowa Avenue
PATERSON, N. J.
Armory 8-1500

Alps Road and Hamburg Turnpike
WAYNE TOWNSHIP, N. J.
Oxbow 4-0072

FOR
SULFONAMIDE
THERAPY

NEW DROP DOSAGE FORM

CHERRY FLAVORED

KYNEX® ACETYL

N¹ Acetyl Sulfamethoxypyridazine

PEDIATRIC DROPS

☐ single, daily-dose effectiveness ☐ rapid, sustained action against sulfa-susceptible organisms ☐ 125 mg. sulfamethoxypyridazine activity per cc. in 10 cc. squeeze bottle

Dosage: First day, 2 cc. (250 mg.) for each 20 lbs. body weight; thereafter, 1 cc. (125 mg.) for each 20 lbs. Should be given once a day immediately after a meal.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York Lederle

TO THE MEDICAL PROFESSION . . .

YOU ARE CORDIALLY INVITED TO EXAMINE

the new ZENITH® EXTENDED RANGE

98% wider frequency range brings in sounds never before reproduced through present conventional hearing aids.

Far less distortion and background noise — Sounds amplified more faithfully

The Royalty of Hearing

Including the world's most attractive eyeglass hearing aid

(Write to us for information concerning a free 30-Day Professional Trial)

ZENITH RADIO CORPORATION OF NEW YORK • Hearing Aid Division

666 FIFTH AVENUE • NEW YORK 19, N. Y.

See listing in local classified directory of authorized Zenith hearing aid dealers

Bringing Comfort to Foot Sufferers Since 1921

SORRENTINO'S

CUSTOM AND ORTHOPEDIC SHOES

1154 E. State Street — **Trenton, N. J.**

Doctors' Prescriptions Filled

BROADLOOM CARPETS — ORIENTAL RUGS

Rugs Washed, Repaired and Stored

B. SHEHADI & SONS, Inc.

CHATHAM
400 Main Street — MErcury 5-8100

EAST ORANGE
51 Central Ave. — ORange 3-5382

RADON • RADIUM

SEEDS • IMPLANTERS • CERVICAL APPLICATORS

THE RADIUM EMANATION CORPORATION

GRAYBAR BUILDING • NEW YORK 17, N. Y.

Wire or Phone MUrray Hill 3-8636 Collect

Specialists in Artificial Human Eyes Exclusively

TRUE TO LIFE

MADE TO ORDER IN PLASTIC OR GLASS IN OUR OWN LABORATORY AND FITTED INDIVIDUALLY

DOCTORS ARE INVITED TO VISIT

REFERRED CASES

CAREFULLY ATTENDED

and

SATISFACTION

GUARANTEED

Plastic or Glass Selections Sent on Memorandum—Eyes Also Fitted from Stock
Implants and Plastic Conformers in Stock.

FRIED & KOHLER, Inc.

665 FIFTH AVENUE
near 53rd Street

NEW YORK CITY, N. Y.
Tel. ELdorado 5-1970

"PRESCRIBE WITH CONFIDENCE"

KATES BROS.

SCIENTIFIC SHOE FITTING

A Shoe and Last for Every Foot

SOLD ON Rx ONLY
CORRECTIVE FOOTWEAR
FOR MEN-WOMEN-CHILDREN

SOLD ON Rx ONLY
OUTFLAIR SHOES
FOR CLUB FEET

177A JEFFERSON AVE.
PASSAIC, N. J.

69 WESTWOOD AVE.
WESTWOOD, N. J.

202 MAIN ST.
HACKENSACK, N. J.

Dennis Brown Splints — in all sizes — carried in stock

doctors

pick up the phone to arrange for a loan

MUrray Hill 2-5000

Only your signature required

It's as simple as that. No visit to this bank necessary. No collateral. No endorsements. Low bank rates. Payments spread over 2 years.

$1500 $2500 $5000

INDUSTRIAL
BANK OF COMMERCE

Main Office: 56 East 42nd St., New York
opposite Grand Central—other offices throughout City
Loans available to residents of New York Metropolitan area, including N. J.

F. G. Hoffritz

GUILDCRAFT OPTICIANS
Zenith Hearing Aids

30 PARK PLACE
ENGLEWOOD, N. J.

Phone LO. 8-7628

ADAMS & SICKLES
W. STATE and PROSPECT STS.
TRENTON, N. J.

24-HOUR PRESCRIPTION SERVICE

Physicians' Supplies
Hospital Supplies

Trenton—Owen 5-6396

Ricci's Shoes, Inc.

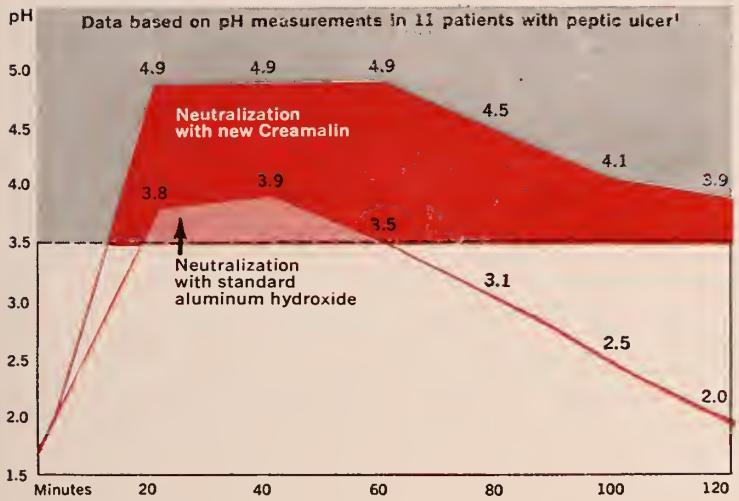
(Specialists in Prescription Shoe Fittings)

43 KINGS HIGHWAY, EAST
HADDONFIELD, NEW JERSEY

PHONE HA. 9-2243

At the site of peptic ulcer

Following determination of basal secretion, intragastric pH was continuously determined by means of frequent readings over a two-hour period.



neutralization is much faster and twice as long with

New CREAMALIN® ANTACID TABLETS

New proof in vivo[1] of the much greater efficacy of new Creamalin tablets over standard aluminum hydroxide has now been obtained. Results of comparative tests on patients with peptic ulcer, measured by an intragastric pH electrode, show that new Creamalin neutralizes acid from 40 to 65 per cent faster than the standard preparation. This neutralization (pH 3.5 or above) is maintained for approximately one hour longer.

New Creamalin provides virtually the same effects as a liquid antacid[2] with the convenience of a tablet.

Nonconstipating and pleasant-tasting, new Creamalin antacid tablets will not produce "acid rebound" or alkalosis.

Each new Creamalin antacid tablet contains 320 mg. of specially processed, highly reactive, short polymer dried aluminum hydroxide gel (stabilized with hexitol) with 75 mg. of magnesium hydroxide. Minute particles of the powder offer a vastly increased surface area for quicker and more complete acid neutralization.

Dosage: Gastric hyperacidity — from 2 to 4 tablets as necessary. Peptic ulcer or gastritis — from 2 to 4 tablets every two to four hours. Tablets may be chewed, swallowed whole with water or milk, or allowed to dissolve in the mouth. How supplied: Bottles of 50, 100, 200 and 1000.

1. Data in the files of the Department of Medical Research, Winthrop Laboratories. 2. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: **J. Am. Pharm. A.** (Scient. Ed.) 48:384, July, 1959.

Winthrop LABORATORIES
New York 18, N. Y.

for peptic ulcer ■ gastritis ■ gastric hyperacidity

REPRESENTATIVE FUNERAL DIRECTORS

OF THE STATE OF NEW JERSEY

Special and Dependable Service Day and Night. Special Attention Given to Hospital Calls, Train and Express Shipments.

PLACE	NAME AND ADDRESS	TELEPHONE
ADELPHIA	C. H. T. Clayton & Son	FReehold 8-0583
ASBURY PARK	Ely Funeral Home, 514 Second Ave.	PRospect 5-0567
ASBURY PARK	Matthews, Francioni & Taylor Funeral Home, 704 7th Ave.	PRospect 5-0021
ATLANTIC CITY	H. M. Gormley Funeral Home, 911 Pacific Ave.	ATlantic City 4-3188
BERGENFIELD	Riewerts Memorial Home, 187 S. Washington Ave.	DUmont 4-0700
BLOOMFIELD	The Howard W. Kopf Funeral Home, 401 Franklin St.	PIlgrim 3-1396
BLOOMFIELD	George Van Tassel's Community Funeral Home	PIlgrim 3-1234
BOONTON	Lewis & Carey Incorporated, 312 W. Main St.	DEerfield 4-0842
CAMDEN	F. T. Walker & E. E. Walker Fun. Home, 743 Chestnut St.	WOodlawn 3-2581
CHATHAM	Wm. A. Bradley Funeral Home, 345 Main St.	MErcury 5-2428
COLLINGSWOOD	Schaffhauser Funeral Home, 983 Haddon Ave.	ULysses 4-5454
CRANBURY	A. S. Cole Son & Co., Main St.	EXport 5-0770
ELIZABETH	Aug. F. Schmidt & Son, 139 Westfield Ave.	ELIzabeth 2-2268
ENGLEWOOD	Greenleaf Funeral Home, Inc., 108 W. Palisade Ave.	ENglewood 3-0416
FREEHOLD	Van Sant Funeral Home, 73 South St.	FReehold 8-0693
HOBOKEN	Failla Memorial Home, 533 Willow Ave.	HOboken 3-0082
JERSEY CITY	Patrick J. Conte Funeral Home, 36 Tuers Ave.	HE 5-6451, DE 3-9259
JERSEY CITY	McLaughlin Funeral Home, 591 Jersey Ave.	OLdfield 3-2266
JERSEY CITY	Donald F. Wood Funeral Residence, 582 Bergen Ave.	DElaware 3-6480
LINDEN	Don McCracken Funeral Home, 2124 St. Georges Ave., E.	ELizabeth 2-3270
LITTLE FALLS	Norman A. Parker Funeral Home, 47 Main St.	CLifford 6-4700
METUCHEN	Runyon Mortuary, 568 Middlesex Ave.	LIberty 8-0149
MOORESTOWN	Harvey H. Brown Funeral Home, 10. W. Main St.	BElmont 5-5555
MORRISTOWN	Raymond A. Lanterman & Son, 126 South St.	JEfferson 9-2880
NEWARK	Barrish Funeral Home, 684 Clinton Ave.	ESsex 3-1551—9179
NEWARK	Beckett's Funeral Home, 120 W. Market St.	MItchell 2-4068
NEWARK	James E. Churchman Service, 132 Clinton Ave.	BIgelow 8-1672
NEWARK	Peoples Burial Co., 84 Broad St.	HUmboldt 2-0707
NEWFOUNDLAND	Stickle Funeral Home, Union Valley Road	OXbow 7-8141
PARAMUS	Vander Plaat Memorial Home, S-113 Fairview Ave.	DIamond 2-3688
PATERSON	Almgren Funeral Home, 336 Broadway	LAmbert 3-3800
PATERSON	R. Charles D. Legg & Sons, 384 Broadway	SHerwood 2-2385
PATERSON	Moore's Home for Funerals, 384 Totowa Ave.	ARmory 8-1500
PATERSON	Scanlan Funeral Homes, 421 Twelfth Ave. at E. 28th St.	SHerwood 2-6433
PATERSON	Vermeulen Memorial Funeral Home, 131 Haledon Ave.	MUlberry 4-3974
POINT PLEASANT	George W. Whateley Funeral Home, 1105 Arnold Ave.	TWinbrook 9-0792
RAHWAY	Lehrer Funeral Home, 275 W. Milton Ave.	FUlton 8-1874
RAMSEY	The Harold Van Emburgh Funeral Home, Inc.	DAvis 7-0030
RIDGEWOOD	C. C. Van Emburgh, Inc., 306 E. Ridgewood Ave.	GIlbert 5-0344
RIVERDALE	George E. Richards, Newark Turnpike	TEmple 5-0164
SOUTH AMBOY	The Gundrum Service, 237 Bordentown Ave.	PArkway 1-0241
SOUTH RIVER	Rezem Funeral Home, 190 Main St.	SOuth RIver 6-1191
SPOTSWOOD	Hulse Funeral Home, 455 Main St.	SOuth River 6-3041
TRENTON	Daniel Brenna Funeral Home, 340 Hamilton Ave.	EXport 3-2857
TRENTON	Ivins & Taylor, Inc., 77 Prospect St.	EXport 4-5186
TRENTON	Poulson & Van Hise, 408 Bellevue Ave.	EXPORT 6-8168
TRENTON	Saul Funeral Homes	JUniper 7-8221 and JUniper 7-0170
WEST ENGLEWOOD	Clifford H. Peinecke Funeral Home, 1312 Teaneck Rd.	TEaneck 7-2332

give yourself a change of pace

Corsaire
18 ft. cruiser-racer class . . . cabin sleeps 4 . . . fine ocean racing record. Unsinkable, non-capsizeable, trailerable. Outboard power available.

Maraudeur
Unsinkable 16 footer, sleeps 2 in fully enclosed cabin, trailerable. Immediate deliveries.

Write to **NAUTICA** CORP.
P.O. Box 26C, Paramus, N. J. — OLiver 2-5146.

SEA SKIFFS

28 FT LUHRS FLYING BRIDGE

23 ft.	109 hp.	**$3320.00**
25 ft.	170 hp.	**4785.00**
28 ft.	188 hp.	**5690.00**

Chapman's

BOAT SALES & SERVICE, INC.

Rt. 70, Riviera Beach, N. J.
(POINT PLEASANT)
Twinbrook 2-1400

PICNIC "17"

IT'S A SAILBOAT MOTOR CRUISER WATER SKIING and FISHING BOAT

See for yourself why the PICNIC 17" with its incredibly low price is the most sensational boat ever developed.

FIBERGLASS can't rot, can't leak, no painting. BIG CABIN, no mast pole to divide space. WIDE DOUBLE BUNK sleeps family of three in cabin, two or three more in cockpit. BUILT-IN TOILET plus galley shelf, ice box and stove. CONVERTIBLE COCKPIT changes from "picnic-syle" to "bench-type" by removal of floor panel, seats six; plenty of room for FISHING, SELF-BAILING.

2 BOATS IN ONE remove hinged mast and add outboard for water skiing, fishing or motor cruising

$1985

LARGE WINDOW AREA • REVERSE SHEER DESIGN • ROLLER REEFING JIB SAIL • ALUMINUM SPARS • INTERNAL SAIL TRACKS • HINGED MAST • CABIN CRUISER with outboard motor • UNSINKABLE, has both sealed air chambers and flotation • PLANING HULL • BELL SHAPE deflects spray • SHOAL DRAFT combination keel-centerboard • STAINLESS STEEL RIGGING, non-ferrous fittings and JAMB CLEATS all standard equipment.

in case you haven't seen a PICNIC "17" send 35 cents in stamps (or coin) to cover handling, for a magnifying viewer, picture series in color and 16-page, 5-color PICNIC brochure to: General Boats Corp.; Dept. M, 32 W. 46th Street, New York 36.

It's a beauty . . . it's a BARBOUR

See the complete line at
your Barbour boat dealer's
. . . or send for colorful literature.

SPORTSMAN (open) MODELS • HARDTOPS • CRUISERS

Sturdy lapstrake construction and Silver Clipper styling make Barbour your best boat buy. Choose from sporty 15-footers to smart 23-foot beauties, some with optional inboard motors. See why Barbour is acclaimed by seasoned skippers!

BARBOUR BOATS, Inc. NEW BERN, NORTH CAROLINA

HOTALING'S BOAT YARD

TOMS RIVER, NEW JERSEY

Chris Craft - Trojan - Pacemaker
Cruisers

"Serving All Your Boating Needs"

2-WAY RADIO COMMUNICATIONS

With mobile radio a doctor can be in constant contact with his office while making house visits. Valuable time is saved in both routine and emergency calls. Let us submit full details.

ARNOLT COMMUNICATIONS, Inc.

429 NO. GROVE STREET EAST ORANGE, N. J.

ORange 4-0500

LAFAYETTE RADIO of Newark

Headquarters for . .

STEREOPHONIC
HIGH FIDELITY
SYSTEMS and
COMPONENTS
for Home and Office

•

Lafayette Radio

24 Central Ave. - Newark 2

Phone: MArket 2-1661

PROFESSIONAL $ MEN! $

YOU CAN ENJOY
BIG SAVINGS WHEN YOU

LEASE YOUR NEW CAR

Leasing can free capital and offer tax advantages. Low monthly rates, no investment, no unforeseen expenses, simplified accounting. No "trade-in" headaches, no maintenance problems! Drive the new car (make and model) you want with tested plans tailored to your needs. Get the facts right away. No obligation.

GENERAL CAR LEASING

Route No. 4 & Grand Ave. - ENGLEWOOD
LO. 9-9011

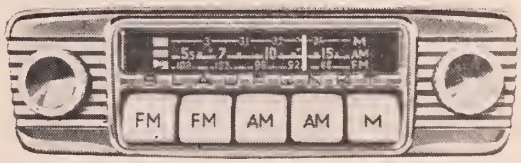
NOW! ASTOUNDING*

in your car

Enjoy the Blaupunkt FM/AM car radio—The world's finest Hi-Fi in motion...Brilliant tone—amazing sensitivity—pin point selectivity—plus uninterrupted reception...no fade-out on bridges, no blackout in underpasses.

FREE! WIN TRIP TO EUROPE FOR 2, via LUFTHANSA Boeing Jet Intercontinental plus 19 other prizes. Nothing to buy or think up. Just visit your dealer for a demonstration of "FM in motion"!

Finest across the Atlantic
LUFTHANSA
GERMAN AIRLINES



BLAUPUNKT

SYMBOL OF QUALITY

TRANSISTORIZED
FM / AM and AM CAR RADIOS

Blaupunkt
REG. U.S. PAT. OFF. BLAUPUNKT-WERKE GMBH HILDESHEIM · GERMANY. A SUBSIDIARY OF ROBT. BOSCH G.M.B.H.

hi-fi IN MOTION

***FOR FREE ENTRY BLANK**—and reprint of informative, exciting article from Electrical Industries Magazine on "ASTOUNDING FM reception"—**MAIL COUPON BELOW**

Robert Bosch Corp., Blaupunkt Car Radio Division
Dept. MJ1, 40-25 Crescent St., L.I. City, 1, N.Y.
or 225 Seventh Street, San Francisco, California

Gentlemen· Please send me free entry blank and reprint mentioned above.

NAME.....

ADDRESS.....

CITY.....ZONE.....STATE.....

MENIC™

C.N.S. stimulant

cerebral vasodilator

in the

senility syndrome

cerebral arteriosclerosis

and **mental confusion**

Each scored tablet contains pentylenetetrazole 100 mg. (1½ gr.) nicotinic acid 50 mg. (5/6 gr.) in bottles of 100 and 500 tablets. Usual dose: 2 MENIC tablets t.i.d., p.c.

Literature and samples available upon request.

MENIC combines the mutually enhancing action of the effective analeptic, pentylenetetrazole, with the proven cerebral vasodilator, nicotinic acid.

MENIC acts to increase oxygen and blood supply to the brain and so helps to overcome the cerebral ischemia and hypoxia responsible for many senility symptoms. Produced physical, mental and social improvement.[1] Menic makes possible a more comfortable, happier life.

1. Levy, S.: J.A.M.A. 153:1260, 1953.

GERIATRIC

GERIATRIC PHARMACEUTICAL CORP.

BELLEROSE, L. I., N. Y.

Pioneers in Geriatric Research

Nathan Hygeia Bag Co.

245 ECHO PLACE NEW YORK 57, N. Y.

Manufacturers of

THE NATHAN OPN-FLAP

HYGEIA MEDICAL BAG

Specially made for

DIABETICS

and those on a

restricted sugar diet!

BORDEN'S

SPECIAL FORMULA

Ice Cream

* * *

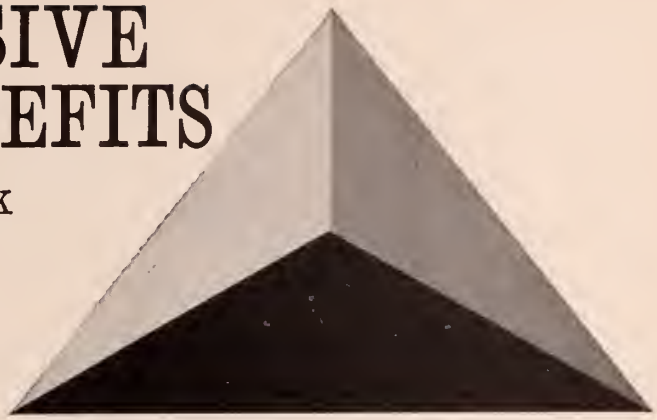
Artificially sweetened . . . only 125 calories per ¼ pint serving. 4 popular flavors.

* * *

At Most Borden, Reid, and Ricciardi Ice Cream Dealers

COMPREHENSIVE OLD AGE BENEFITS

- ▲ brightens the outlook
- ▲ lightens the load of poor nutrition
- ▲ heightens tissue/bone metabolism



NEW

1 small capsule every morning

GEVRESTIN®

Geriatric Vitamins-Minerals-Hormones-d-Amphetamine Lederle

Each capsule contains: Ethinyl Estradiol 0.01 mg. • Methyl Testosterone 2.5 mg. • d-Amphetamine Sulfate 2.5 mg. • Vitamin A (Acetate) 5,000 U.S.P. Units • Vitamin D 500 U.S.P. Units • Vitamin B_{12} with AUTRINIC® Intrinsic Factor Concentrate 1/15 U.S.P. Unit (Oral) • Thiamine Mononitrate (B_1) 5 mg. • Riboflavin (B_2) 5 mg. • Niacinamide 15 mg. • Pyridoxine HCl (B_6) 0.5 mg. • Calcium Pantothenate 5 mg. • Folic Acid 0.4 mg. • Choline Bitartrate 25 mg. • Inositol 25 mg. • Ascorbic Acid (C) as Calcium Ascorbate 50 mg. • l-Lysine Monohydrochloride 25 mg. • Vitamin E (Tocopherol Acid Succinate) 10 Int. Units • Rutin 12.5 mg. • Ferrous Fumarate (Elemental iron, 10 mg.) 30.4 mg. • Iodine (as KI) 0.1 mg. • Calcium (as $CaHPO_4$) 35 mg. • Phosphorus (as $CaHPO_4$) 27 mg. • Fluorine (as CaF_2) 0.1 mg. • Copper (as CuO) 1 mg. • Potassium (as K_2SO_4) 5 mg. • Manganese (as MnO_2) 1 mg. • Zinc (as ZnO) 0.5 mg. • Magnesium (MgO) 1 mg. • Boron (as $Na_2B_4O_7.10H_2O$) 0.1 mg. Bottles of 100, 1000.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

GREETINGS FROM

Kohler's Swiss Chalet

120 W. PASSAIC STREET

ROCHELLE PARK, N. J.

Diamond 2-2711

MILLSIDE FARMS

Producers of

HOMOGENIZED Vitamin "D" Milk

FROM

GOLDEN GUERNSEY CATTLE

RIVERSIDE, NEW JERSEY

Phone Hobart 1-0046

PARK RIDGE

COAT, APRON, TOWEL AND LINEN SERVICE

•

A Complete Linen Service for . . .

PROFESSIONAL OFFICES - STORES

RESTAURANTS - FACTORIES - HOTELS

•

UNIFORMS TOWELS APRONS

GOWNS NAPKINS

•

182 HOBART ST. RIDGEFIELD PARK, N. J.

HUBBARD 7-1038

PRESCRIPTION PHARMACISTS

TO THE MEMBERS OF

The Medical Society of New Jersey

PLACE	NAME AND ADDRESS	TELEPHONE
BELLEVILLE	Joralemon Pharmacy, 531 Joralemon St.	PLym'th 9-4535-9858
BERGENFIELD	Horn's Pharmacy, 475 So. Washington Ave.	DUmont 4-1119
BERGENFIELD	Merit Pharmacy, 8 So. Washington Ave.	DUmont 4-9844
BOONTON	Preston Drugs, Del's Village Shopping Center	DEerfield 4-3466
BOUND BROOK	Lloyd's Drug Store, 305 East Main St.	ELliot 6-0150
BUTLER	Pink's Pharmacy, 178 Main St.	BUtler 9-0090, 9-1063
CLIFTON	Fleischner's Pharmacy, 652 Allwood Road	PRescott 7-6689
CLOSTER	Mid Town Pharmacy, 237 Closter Dock Road	CLoster 5-0070
DOVER	Leslie's Drugs, Inc., 9 East Blackwell St.	FOxcroft 6-1405
DUMONT	Lenrow's Pharmacy Inc., 10 W. Madison Ave.	DUmont 4-0842-1500
EDISON TOWNSHIP	Walter's Pharmacy, 1034 Amboy Ave.	LIberty 8-2614
EMERSON	Emerson Pharmacy, 201 Kinderkamack Road	COlfax 2-4999
FLEMINGTON	Green's Pharmacy, 52 Main St.	FLemington 108
FORDS	Fords Pharmacy, Inc., 550 New Brunswick Ave.	HIllcrest 2-4568
GLOUCESTER	King's Pharmacy, Broadway and Market Sts.	GLouc't'r 6-0781-8970
HAWTHORNE	Melcon's Pharmacy, 207 Diamond Bridge Ave.	HAwthorne 7-1546
HIGHLANDS	Highlands Pharmacy, 148 Bay Ave.	HIghlands 3-1058
JERSEY CITY	The Cole Pharmacy, Inc., 710 Grand St.	Delaware 3-9294
JERSEY CITY	J. B. Feinberg Pharmacy, 659 Newark Ave.	OLdfield 3-6376
JERSEY CITY	Honiberg Drug & Surgical Supply Co., 618 Newark Ave.	SWarthmore 8-6700
JERSEY CITY	Lauria's Pharmacy, 768 West Side Ave.	HEnderson 3-1519
JERSEY CITY	S. Taube Inc., 250 Jackson Ave.	HEnd'rs'n 3-2606-0642
JERSEY CITY	Waters Pharmacy, 492 Jackson Ave.	DElaware 3-3043
KEYPORT	Sav-On-Drugs, J. Meisler, opp. Post Office	COlfax 4-0904
LAKEWOOD	Alpert's Pharmacy, 224 Clifton Ave., Cor. 3rd St.	FOxcroft 3-3600
LITTLE FALLS	Swisher Pharmacy, Inc., 94 Main St.	CLifford 6-0835
METUCHEN	Wernik's Pharmacy, 412 Main St.	LIberty 8-0123
MILLTOWN	Milltown Pharmacy, 21 No. Main St.	MIlltown 8-0081
MILLVILLE	Richard H. Knowles Pharmacy, 600 No. High St.	TAylor 5-0721
MOORESTOWN	Stiles' Pharmacy, 75 East Main St.	BElmont 5-0088
MORRISTOWN	Carrell's Pharmacy (N. E. Corrao, Pharm.) 31 South St.	JEfferson 9-0143
MORRISVILLE, PA.	Pryor's Pharmacy, Bridge St. & Penna. Ave.	CYpress 5-7416
MOUNT HOLLY	Goldy's Pharmacy, Main & Washington Sts.	AMherst 7-2250
MOUNT HOLLY	Mount Holly Pharmacy, 64 Main St.	AMherst 7-0453
NEWARK	Marquier's Pharmacy, Sanford & So. Orange Aves.	ESsex 3-7721
NEWARK	Smith's Pharmacy, 315 So. Orange Ave.	MArket 3-1514

(Continued on following page)

PRESCRIPTION PHARMACISTS

TO THE MEMBERS OF

The Medical Society of New Jersey

(Continued from preceding page)

NEW BRUNSWICK	Bode Drug Co., 120 French St.	KIlmer 5-2676
NEW BRUNSWICK	Hoagland's Drug Store, 365 George St.	KIlmer 5-0048
NEW BRUNSWICK	Rutgers Pharmacy, 429 Livingston Ave.	CHarter 9-6666
NEW BRUNSWICK	Tobin's Drug Store, 335 George St.	CHarter 9-0780
NEW BRUNSWICK	Zajac's Pharmacy, 225 George St.	KIlmer 5-0582
OCEAN CITY	Selvagn's Pharmacy, 862 Asbury Ave.	OCean City 3535
OLD BRIDGE	Old Bridge Pharm., Inc., Englishtown Rd. & 7th St.	CLifford 4-5454
ORANGE	Highland Pharmacy, 536 Freeman St.	ORange 3-1040
ORANGE	Hollywood Pharmacy, 49 Central Ave.	ORange 5-1752
PASSAIC	Wollman Pharmacy, 143 Prospect St.	PRescott 9-0081
PATERSON	Vallario's Pharmacy, 357 Totowa Ave.	ARmory 4-2139
PAULSBORO	Nastase's Pharmacy, 762 Delaware St.	PAulsboro 8-1569
PERTH AMBOY	Jacobs' Drug Store, 434 Amboy Ave.	VAlley 6-3273
PITMAN	Lodge's Pharmacy, 39 So. Broadway	LUther 9-2392
PRINCETON	The Thorne Pharmacy, 168 Nassau St.	WAlnut 4-0077
RAHWAY	Kirstein's Pharmacy, 74 East Cherry St.	RAhway 7-0235
RIDGEFIELD PARK	Lloyd's Prescriptions, 209 Main St.	DIamond 2-8383
RIDGEWOOD	Davis Pharmacy, Inc., 2 Wilsey Square	OLiver 2-2444
ROCKAWAY	Leslie's Drugs, Inc., 36 West Main St.	OAkwood 7-5544
RUMSON	Rumson Pharmacy, W. E. Fogelson	RUmson 1-1234
SHREWSBURY	Shrewsbury Pharmacy, 570 Broad St.	SHadyside 1-4874
SOMERDALE	Balaban's Pharmacy, Maiden Lane & White Horse Pike	STerling 3-2956
SOUTH AMBOY	Madura Pharmacy, 115 N. Broadway	PArkway 1-1732
SOUTH ORANGE	Taft's Pharmacy, 2 South Orange Ave.	SOuth Orange 2-0063
TRENTON	Adams & Sickles, State & Prospect Sts.	OWen 5-6396
TRENTON	Delahanty's Pharmacy, State St. at Chambers	EXport 3-4261
TRENTON	Episcopo's Pharmacy, Chambers & Liberty Sts.	EXport 3-3017
TRENTON	Foy's Drug Store, 3024 So. Broad St.	EXport 3-2367
TRENTON	H. S. Hughes, Thatcher Pharmacy, 401 Hudson St.	EXport 2-5616
TRENTON	Kehr's Pharmacy, A. F. Capriotti, R. P., Manager	OWen 5-6807
TRENTON	Lee's Sun Ray Pharmacy, 940 Parkway Ave.	TUxedo 2-3456
UNION	Perkins Union Center Pharmacy	MUrdock 6-0877
UNION CITY	Husni's Pharmacy, 2503 Bergenline Ave.	UNion 5-2577
UNION CITY	Jos. Parentini's Pharmacy, Inc., Charles H. Arnoldi	UNion 7-4806
VENTNOR	Barsky Drugs, Inc., 5217 Atlantic Ave.	ATlantic City 2-1177
WEST NEW YORK	The Owl Pharmacy, 6611 Bergenline Ave.	UNion 5-0384
WEST ORANGE	West Orange Pharmacy, 443 Main St.	ORange 4-9824
WOODBURY	Resnick's So. Broad Pharmacy, 305 So. Broad St.	TIlden 5-0647
WRIGHTSTOWN	Bowen's Pharmacy, 152 Fort Dix Road	RAymond 3-2176

For Doctors, Their Patients, and Others Who Prefer Raw Milk . . .

WALKER-GORDON CERTIFIED RAW MILK

In keeping with the Walker-Gordon policy of producing the highest quality Milk possible, and providing it in whatever form the public may request, Certified Raw Milk is made available in many areas through leading milk dealers. Certified Raw Milk is produced in accordance with the highest standards of the American Association of Medical Milk Commissions . . . and more than 60 years of distribution prove it to be *clean—safe—nutritious.* We'll be glad to give you full information on request.

Guaranteed Free of Penicillin

WALKER-GORDON CERTIFIED MILK FARM, ***Plainsboro, N. J. ★ SWinburne 9-1234***

New York: WAlker 5-7300 ☆ **Phila.: LOcust 7-2665**

Also producers of Certified Posteurized, Homogenized-Vit. D, Skimmed, Acidophilus, and Fresh Lo-Sodium Milks

Dugan's

"Bakers for the Home"

New - LITE DIET BREAD

(White Bread Baked Without Shortening)

Calories per Slice 42 Calories per Oz. 70

ALSO

SALT-FREE BREAD

GLUTEN AND PROTEIN BREADS

100% WHOLE WHEAT

100% Whole Wheat Crackers

New York New Jersey

Connecticut Pennsylvania

"AT YOUR DOOR OR TO YOUR STORE, IT'S DUGAN'S FOR BETTER BAKED GOODS"

Phone for Delivery

HUmboldt 2-6007 in Newark

(or your local phone book for branch nearest you)

NOW! **DIABETICS CAN ENJOY**

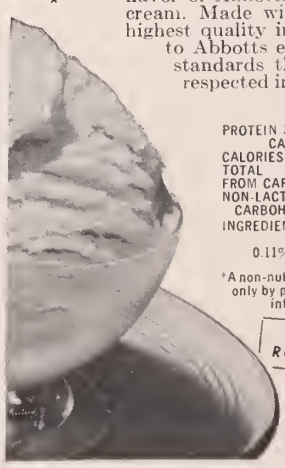
(UNDER MEDICAL ADVICE)

Abbotts

ARTIFICIALLY SWEETENED

ICE CREAM

Your patients whose sugar intake is restricted will relish the extra delicious flavor of Abbotts new, sugar-free ice cream. Made with infinite care and highest quality ingredients according to Abbotts exacting standards—standards that are most highly respected in the dairy industry.



COMPOSITION

PROTEIN 3.52% MILK FAT 10.52%

CARBOHYDRATES 21.35%

CALORIES PER OUNCE	AVOIR.	FLUID
TOTAL	55.02	33.31
FROM CARBOHYDRATES	24.21	14.66
NON-LACTOSE CARBOHYDRATES	18.03	10.92

INGREDIENTS: CREAM, MILK, SORBITOL, STABILIZER AND 0.11% CYCLAMATE CALCIUM*

*A non-nutritive artificial sweetener for use only by persons who must restrict their intake of ordinary sweets.

IN HANDY ROUND PINTS

At Abbotts and Jane Logan Dealers

Abbotts Dairies, Inc.

Raise the Pain Threshold

WITH MAXIMUM SAFE ANALGESIA

Phenaphen with Codeine provides intensified codeine effects with control of adverse reactions. It renders unnecessary (or postpones) the use of morphine or addicting synthetic narcotics, even in many cases of late cancer.

Three Strengths —

PHENAPHEN NO. 2
Phenaphen with Codeine Phosphate ¼ gr. (16.2 mg.)

PHENAPHEN NO. 3
Phenaphen with Codeine Phosphate ½ gr. (32.4 mg.)

PHENAPHEN NO. 4
Phenaphen with Codeine Phosphate 1 gr. (64.8 mg.)

Also —

PHENAPHEN In each capsule

Acetylsalicylic Acid 2½ gr. . (162 mg.)
Phenacetin 3 gr. . . . . (194 mg.)
Phenobarbital ¼ gr. . . . . (16.2 mg.)
Hyoscyamine sulfate . . . . . (0.031 mg.)

PHENAPHEN® WITH CODEINE

Robins

Robins

A. H. ROBINS CO., INC., RICHMOND 20, VIRGINIA

Ethical Pharmaceuticals of Merit since 1878

INFORMATION FOR READERS AND CONTRIBUTORS

The Journal is the official organ of The Medical Society of New Jersey, published monthly under the direction of the Committee on Publication. *The Journal* is released on or about the tenth of each month, and a copy is sent to each member of the Society.

Change of Address: Notice of change of address should be sent promptly to The Medical Society of New Jersey, P. O. Box 904, Trenton 5, New Jersey.

Communications: Members are invited to submit to *The Journal* any suggestions for the welfare of the Society, as well as comments or criticisms of any material in *The Journal*. All such communications should be directed to the Editorial Office of *The Journal*. The Publication Committee reserves the right to publish, reject, edit or abbreviate all communications submitted to it.

Contributions: Mansucripts submitted to *The Journal* should be typewritten, double-spaced on letter-size (about 8½ by 11 inch) paper, and forwarded to the Editorial Office at the address below. The Publication Committee expressly reserves the right to reject any contributions, whether solicited or not; and the right to abbreviate or edit such contributions in conformity with the needs and requirements of *The Journal*. Galley-proofs of edited or abbreviated manuscripts will be submitted to authors for approval before publication. Every care will be taken with the submitted material, but *The Journal* will not hold itself responsible for loss or damage to manuscripts. Authors are required to submit original copies only, and are urged to keep carbon copies for reference. It is understood that material is submitted here for exclusive publication in this *Journal*.

Illustrations: Authors wishing illustrations for their articles will submit glossy prints or original sketches, from which cuts or plates will be made by *The Journal*. The cost of making such cuts will be borne by the author, who will, after publication, receive the cuts for his own use. The cost of these cuts varies with the size and type of the illustration. An estimate of the cost will be submitted to authors before the cuts are ordered.

THE JOURNAL OF THE MEDICAL SOCIETY OF NEW JERSEY
P. O. Box 904, Trenton 5, New Jersey

ORANGE PUBLISHING COMPANY

PRINTERS

116 Lincoln Avenue, Orange, New Jersey

CHANGE OF ADDRESS

In the event of a change of address or failure to receive THE JOURNAL regularly fill out this coupon and mail at once to

THE MEDICAL SOCIETY OF NEW JERSEY, P. O. Box 904, Trenton 5, N. J.

Change my address on mailing list

From .....

To .....

Date..... Signed..... M.D.

CLASSIFIED ADVERTISEMENTS

WANTS FOR SALE TO LET

SITUATIONS ETC.

Send replies to box number c/o **The Journal** P. O. Box 904, Trenton 5, N. J.
$3.00 for 25 words or less: additional words 5c each Forms close 15th of the Preceding Month.

GENERAL SURGEON—34 years. Board eligible. Trained large city hospital. Desires association with group or individual in New York or New Jersey. Write Box HM, c/o THE JOURNAL.

ASSISTANT TO MEDICAL DIRECTOR—for 280-bed County, accredited Hospital. Requirements, experience in Chest Diseases, Internal Medicine (Geriatrics); New Jersey State license. Modern furnished accommodation and full maintenance at nominal cost; excellent pension plan combined with Social Security, also free hospitalization, paid vacation, sick leave and holidays. Salary depending on experience and qualifications. Contact Eugene Nargiello, M.D., Superintendent and Medical Director, John E. Runnells Hospital for Chest Diseases, Berkeley Heights, New Jersey.

SENIOR PHYSICIAN—for 280-bed County, accredited Hospital. Requirements, approved internship and training in Chest Diseases, experience in Internal Medicine (Geriatrics); eligible for license in New Jersey or licensed in any State. Modern furnished accommodation and full maintenance at nominal cost; excellent pension plan combined with Social Security, also free hospitalization, paid vacation, sick leave and holidays. Salary depending on training and experience. Contact Eugene Nargiello, M.D., Superintendent and Medical Director, John E. Runnells Hospital for Chest Diseases, Berkeley Heights, New Jersey.

INDUSTRIAL PHYSICIAN—Large Phila. industrial firm has immediate opening in its Medical Division for a physician to assist in the implementation of its Employe Medical Program. Headquarters in Phila. with some travel. Licensed or eligible for licensing in Penna. Send full details of education, experience, etc. to H. A. Smith, P.O. Box 7258, Phila. 1, Pa. All replies will be held in strictest confidence.

PEDIATRICIAN—Office for rent in building with two internists in populated, rapidly growing, excellent area in central New Jersey. Opportunity for association in near future if so desired. Write Box AB, c/o THE JOURNAL.

QUALIFIED OR BOARD ELIGIBLE PSYCHIATRIST—for private active treatment unit. Many community attractions. Opportunity for seminars and analysis. Liberal benefits and future opportunity. *Write*: V. Gerard Ryan, Elmcrest Manor, Portland, Connecticut.

PHYSICIAN WANTED—Medical Department of non-manufacturing industry located in downtown Newark requires services of a physician under age 45 years, full-time, who is interested in occupational medicine as a career. Write Box NJ, c/o THE JOURNAL.

GENERAL PRACTITIONER WANTED—Partnership of two young men in rapidly growing general practice need a third physician to join them. Located in new medical-center type offices in South Jersey only fifteen miles from Philadelphia. Please send full details. Write Box ST, c/o THE JOURNAL.

IN MONTCLAIR—TO SHARE—Completely and attractively furnished physician's office beginning at any time. Has been doctor's office for many years. Phone: PIlgrim 4-0263 until August 1st, and PIlgrim 4-7654 thereafter.

PLAINFIELD, N. J., 1310 West 7th St.—Two suites available, newly built professional building. Wood panelled waiting room, nurses' station, 3 examination rooms one suite, and 2 examination rooms the other suite. Private lavatories, central heating and air conditioning, on site parking. Rent reasonable. Call WAverly 6-3238. One suite now occupied by dentist.

RUTHERFORD, N. J.—Briar Hall Apartments, 130 Orient Way. 5 rm. office. Pvt. street entrance. Luxury elev. bldg. centrally located. Suitable MD or DDS. Present doctor vacating about July 1. GEneva 8-6700 or WEbster 9-3139.

AIR-CONDITIONED OFFICES—First or second floor, with parking facilities; flexible room arrangement; desirable Montclair location near hospitals and bus lines. Living facilities available. Write Box GC, c/o THE JOURNAL.

(Continued on following page)

CLASSIFIED ADVERTISEMENTS

(Continued from preceding page)

FOR RENT—Attractive air-conditioned office, equipped; x-ray, basal metabolism, diathermy, etc. Large consultation room, laboratory, 3 work rooms, common waiting-room. 3 bus lines. Rent reasonable. Will share if desired. ESsex 2-7711.

NEW, AIR-CONDITIONED, FIRST FLOOR OFFICE AVAILABLE—with parking facilities, flexible room arrangement; desirable Madison location, near hospital, shopping center and bus lines. Call HU. 2-3443 or FR. 7-7746.

MEDICAL ARTS BUILDING OF JERSEY CITY—8-12 Clifton Place, Jersey City, N. J. Suites available—for professional use only—air-conditioned building. For information call DElaware 3-7573. Brochure upon request.

NEW MEDICAL SUITES AVAILABLE in excellent location; at line of Hudson & Bergen Counties. One-story building with parking; all modern conveniences supplied. $160-$175/mos. Bergenline Professional Bldg., 8609 Bergenline Ave., North Bergen, N. J. UN. 9-0850.

IN MONTCLAIR—2 or 3 large rooms, ideal location, air-conditioned. Separate entrance. Parking facilities. PI. 4-2030.

MONTCLAIR—Second floor of attractive corner property, excellent location, air-conditioned. Separate entrance. Parking. PI. 4-2030.

EDISON—Lease first floor modern professional building, 6 rooms air-conditioned; on site parking; newly built-up residential neighborhood. Jos. Ostrower, 104 Main Street, Woodbridge, N. J.

WONDERFUL OPPORTUNITY for young doctor to establish practice in beautiful new rapidly expanding development in N. J., with many young families (40 miles from NYC). Ideal new home-office combination available. Very moderate financial arrangement. Write Box WJ, c/o THE JOURNAL.

MORRISTOWN, N. J.—44 Maple Ave. Office, waiting room, 2 consulting rooms, 2 treatment rooms, lab. Parking space. A-1 professional location. Call JE. 8-4746.

TEANECK, N. J.—Death of prominent physician necessitates sale of 2-year old 7-room residence and 6-room office and equipment. Located on Doctors Row on bus line. Five miles to George Washington Bridge. Phone TEaneck 6-3211 or write Mrs. Walter Farr, 951 Queen Anne Rd., Teaneck, N. J.

FOR SALE—In Bridgeton, N. J. House including offices of the late Dr. Charles Fromkin. House includes lovely living room, large center hall, large dining room, kitchen, and pantry. Upstairs, three large bedrooms and bath. The offices include waiting room, consultation room, examining room, and lavatory. For information contact Mrs. Charles Fromkin, 20 Bank St., Bridgeton, N. J. Telephone: BRidgeton 9-1483.

FOR SALE—Haddonfield, N. J. Practice, general and specialty of metabolic obesity. Street level office suite, centrally located; bus lines and parking available. Rented suite includes modernistic reception and consultation rooms; examination-surgical room; large reducing salon, fully equipped; dressing room; two lavatories; receptionist office. Complete records. Will introduce one month. Moving to West. For further information call HAzel 9-1214 or write Box ES, c/o THE JOURNAL.

EQUIPMENT FOR SALE—200 MA x-ray (G.E.) with spot device; examining room equipment, other furniture, etc. May be bought separately. Excellent value. Internist leaving to change specialty. TEaneck 3-0012.

RADIOLOGIST'S EQUIPMENT FOR SALE—Reasonable. Office rental optional. Complete diagnostic and therapy laboratory ready to operate. Located in busy industrial city with rapidly developing suburbs. Contact: Mrs. M. Abrams, 20 Grand View Ave., West Orange, N. J. RE 1-0019, RE 1-0095.

Today's Health
Published by the American Medical Association

Published by the

American Medical Association for the American Family

TODAY'S HEALTH is a Good Buy in Public Relations

GIVE GIFT SUBSCRIPTIONS TO YOUR PATIENTS AND FRIENDS

Today's Health - AMA
535 N. Dearborn St.
Chicago 10, Illinois

Please enter the following Subscription for the term checked:

☐ 2 YEARS $5.00 ☐ 1 YEAR $3.00
(U.S., U.S. Poss. & CANADA)

Name _____

Address _____

City _____ Zone _____ State _____

PLEASE PRINT—Use separate sheet for additional names.

SJ

3-way support for the aging patient...

ASSISTS PROTEIN UPTAKE
IMPROVES MENTAL OUTLOOK
AIDS NUTRITIONAL INTAKE

NEW

1 small capsule every morning

GEVRESTIN®

Geriatric Vitamins-Minerals-Hormones-d-Amphetamine Lederle

Each capsule contains: Ethinyl Estradiol 0.01 mg. • Methyl Testosterone 2.5 mg. • d-Amphetamine Sulfate 2.5 mg. • Vitamin A (Acetate) 5,000 U.S.P. Units • Vitamin D 500 U.S.P. Units • Vitamin B_{12} with AUTRINIC® Intrinsic Factor Concentrate 1/15 U.S.P. Unit (Oral) • Thiamine Mononitrate (B_1) 5 mg. • Riboflavin (B_2) 5 mg. • Niacinamide 15 mg. • Pyridoxine HCl (B_6) 0.5 mg. • Calcium Pantothenate 5 mg. • Folic Acid 0.4 mg. • Choline Bitartrate 25 mg. • Inositol 25 mg. • Ascorbic Acid (C) as Calcium Ascorbate 50 mg. • l-Lysine Monohydrochloride 25 mg. • Vitamin E (Tocopherol Acid Succinate) 10 Int. Units • Rutin 12.5 mg. • Ferrous Fumarate (Elemental iron, 10 mg.) 30.4 mg. • Iodine (as KI) 0.1 mg. • Calcium (as $CaHPO_4$) 35 mg. • Phosphorus (as $CaHPO_4$) 27 mg. • Fluorine (as CaF_2) 0.1 mg. • Copper (as CuO) 1 mg. • Potassium (as K_2SO_4) 5 mg. • Manganese (as MnO_2) 1 mg. • Zinc (as ZnO) 0.5 mg. • Magnesium (MgO) 1 mg. • Boron (as $Na_2B_4O_7.10H_2O$) 0.1 mg. Bottles of 100, 1000.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

FAIRLEIGH DICKINSON UNIVERSITY

CAMPUSES AT RUTHERFORD, TEANECK and FLORHAM PARK, NEW JERSEY

SCHOOL OF DENTISTRY

MEDICAL TECHNOLOGY — Four-year course including one year in approved hospital. Bachelor of Science degree.

MEDICAL ASSISTANT — Two-year course. Associate in Arts degree.

NURSING — Two-year course. Associate in Arts degree. Eligibility for R.N. examinations. Bachelor of Science course for students already possessing R.N.

DENTAL HYGIENE — Two-year course. Associate in Arts degree.

PHONE
CH. 2-2330

for well trained highly qualified personnel

MEDICAL
OFFICE ASSISTANTS OR SECRETARIES

Co-Ed (Founded 1936)

N. Y. State Licensed Day-Eve. Courses
Trained by Physicians for Physicians

Eastern *request Free Cat. 7*

SCHOOL FOR PHYSICIANS' AIDES
85 Fifth Ave. (16th St.) New York 3, N. Y.
affiliated with CARNEGIE INSTITUTE, INC. *Cleveland, O.*

MAKELY

MEDICAL & TECHNICAL PUBLICATIONS

242 LYONS AVENUE
Newark 12, N. J.

WAverly 3-1688

one child has epilepsy...

even her companions might not know—if her seizures are controlled with medication

"...nowadays our approach should be, as far as possible, to protect the patient with sufficient medicine and allow him to live as much as possible the life of a normal child."[1] Under proper medical care, epileptic children may—and should—participate in the general physical activities of their normal playmates.[2]

for clinically proved results in control of seizures

DILANTIN® SODIUM KAPSEALS® *outstanding performance in grand mal and psychomotor seizures:"In the last 15 years new anticonvulsant agents have come into clinical use but they have not replaced diphenylhydantoin* [DILANTIN] *as the most effective single agent for a variety of reasons."*[3] DILANTIN Sodium *(diphenylhydantoin sodium, Parke-Davis) is available in several forms including Kapseals of 0.03 Gm. and of 0.1 Gm., in bottles of 100 and 1,000.*

other members of THE PARKE-DAVIS FAMILY OF ANTICONVULSANTS

for grand mal and psychomotor seizures: PHELANTIN® Kapseals *(Dilantin 100 mg., phenobarbital 30 mg., desoxyephedrine hydrochloride 2.5 mg.), bottles of 100• for the petit mal triad:* MILONTIN® Kapseals, *(phensuximide, Parke-Davis) 0.5 Gm., bottles of 100 and 1,000; Suspension, 250 mg. per 4 cc., 16-ounce bottles.* CELONTIN® Kapseals *(methsuximide, Parke-Davis) 0.3 Gm., bottles of 100.*

Literature supplying details of dosage and administration available on request.

Bibliography: (1) Scott, J. S., & Kellaway, P.: *M. Clin. North America* 42:415 (March) 1958. (2) Ganoug, L. D., in Green, J. R., & Steelman, H. F.: Epileptic Seizures, Baltimore, Williams & Wilkins Company, 1956, pp. 98-102. (3) Bray, P. F.: *Pediatrics* 23:151, 1959.

26460

PARKE-DAVIS

PARKE, DAVIS & COMPANY • Detroit 32, Michigan

'Stelazine' has little if any soporific effect. "... patients who reported drowsiness as a side effect mentioned that they did not fall asleep when they lay down for a daytime nap. It is quite possible that, in some instances, 'drowsiness' was confused with unfamiliar feelings of relaxation."[1]

IN ANXIETY—RELAXATION RATHER THAN DROWSINESS

Available for use in everyday practice: Tablets, 1 mg., in bottles of 50 and 500; and 2 mg., in bottles of 50.

N.B.: For information on dosage, side effects, cautions and contraindications, see available comprehensive literature, PDR, or your S.K.F. representative.

STELAZINE®

brand of trifluoperazine

1. Goddard, E.S.: in *Trifluoperazine, Further Clinical and Laboratory Studies*, Philadelphia, Lea & Febiger, 1959.

SMITH KLINE & FRENCH

leaders in psychopharmaceutical research

THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

Entered as second-class matter September 5, 1906, at the post office at Orange, New Jersey, under Act of March 3, 1879

Second Class Postage Paid at Orange, N. J.

VOL. 57, NO. 8 — AUGUST, 1960 — Subscriptions, $3.00 per Year; Single Copies, 30 Cents

CONTENTS—Pages 449 to 510

LIBRARY
AUG 1 3 1960
NEW YORK ACADEMY OF MEDICINE

EDITORIALS— Page

- **Opiferque** — 449
- **Fall and Rise of Uroscopy** — 450
- **Medical Prepayment and Philosophy** — 450
- **George N. J. Sommer (1874-1960)** — 451

ORIGINAL ARTICLES—

- **The Science and Art of Medicine**—Jesse McCall, M.D., Newton, N. J. — 452
- **Problems of Aging**—Ulysses M. Frank, M.D., Millburn, N. J. — 455
- **Psychoneuroses in Medical Practice**—M. J. Rowen, M.D., Elizabeth, N. J. — 460
- **Audio-Frequency Generator in the Doctor's Office**—Ralph A. Hall, M.D., Westfield, N. J. — 465
- **Influence of Protein Diet on Blood Volume**—Catalino Arenas, M.D. and Robert J. Ryan, M.D., Trenton, N. J. — 469
- **Psychiatric Symptoms in Brain Tumors**—Samuel A. Sandler, M.D., Hackensack, N. J. — 471
- **Relief of Muscular Spasm and Pain in Orthopedic Conditions**—Kenneth Jordan, M.D., Montclair, N. J. — 475
- **Treatment of Pneumococcus Meningitis**—Abraham M. Balter, M.D. and Irving E. Blecher, M.D., Lyons, N. J. — 479
- **Prednisolone-Hydroxyzine in Arthritis**—Herman H. Tillis, M.D., Newark, N. J. — 485

ORIGINAL ARTICLES— Page

- **Griseofulvin Therapy for Tinea Capitis**—Samuel Fisher, M.D., et al., Paterson, N. J. — 489

HISTORICAL ARTICLE—

- **Military Surgery in the American Revolution**—C. Malcolm B. Gilman, M.D., Red Bank, N. J. — 491

STATE ACTIVITIES—

- Society for Relief of Widows and Orphans — 464
- Diet Manual — 470
- Epilepsy Pamphlet Available — 490
- Board of Trustees — 497
- New Professional Liability Plan — 497
- New Jersey Diplomates in Gynecology — 498
- Funded Payment for Eye Care — 499
- Honor for Mary Bacon, M.D. — 500
- Encephalitis and the Private Practitioner — 501
- Supplementary List No. 6 to the 1959-60 Membership Directory — 502

LETTER TO THE JOURNAL — 503

OBITUARIES — 503

ANNOUNCEMENTS — 504

COUNTY SOCIETY REPORTS — 505

BOOK REVIEWS — 507

Roster of Officers and Committees, Pages 3A - 6A

Place of Publication, Printing and Mailing, 116-118 Lincoln Ave., Orange, N. J.

Editorial and Executive Offices of the Society 315 West State St., Trenton 8, N. J.

Address all communications FOR PUBLICATION to editorial office at P.O. Box 904, Trenton 5, N. J.

Telephone EXport 4-3154

Published Monthly Since 1904

Acceptance for mailing at special rate of postage provided for in Sec. 1103, Act of Oct. 3, 1917, authorized July 29, 1918.

Copyright 1960 by
The Medical Society of New Jersey

NEW PROFESSIONAL LIABILITY INSURANCE PROGRAM APPROVED BY YOUR MEDICAL SOCIETY

American Mutual has been appointed by the 1960 House of Delegates of The Medical Society of New Jersey to provide your professional liability insurance. (See article on page 497)

This means protection by the *first* American liability insurance company. Long experience in the field of professional liability insurance has led to a practical solution of one of the important problems—that of *loss control*—faced by the medical profession.

Insurance for Professional Liability and Professional Premises Liability is available to members of The Medical Society of New Jersey. Professional Liability Insurance is also available to the registered nurses and qualified technicians employed by our policyholder doctors.

Protection for Libel, Slander and Defamation of Character arising out of activities on committees of State and County Medical Societies and committees of licensed hospitals is furnished to all insured doctors.

Please address your request for further information about this program to:

American Mutual Liability Insurance Company

PROFESSIONAL LIABILITY DEPARTMENT

68 SOUTH HARRISON STREET EAST ORANGE, NEW JERSEY

JOSEPH A. BRITTON, Manager ORANGE 3-2575

HOME OFFICE: WAKEFIELD, MASS.

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766

PLACE OF PUBLICATION, PRINTING AND MAILING, 116 LINCOLN AVE., ORANGE, N. J.

EXECUTIVE AND EDITORIAL OFFICES, 315 WEST STATE STREET, TRENTON 8, N. J. Tel. EXport 4-3154

(MAILING ADDRESS: P.O. BOX 904, TRENTON 5, N. J.)

Mr. Richard I. Nevin, *Executive Officer* ..... Trenton
Mrs. Edith L. Madden, *Administrative Secretary and Convention Manager* ..... Trenton
Henry A. Davidson, *Editor* ..... Cedar Grove
Mrs. Miriam N. Armstrong, *Assistant Editor* ..... Trenton

OFFICERS

President, Jesse McCall ..... Newton
President-Elect, Ralph M. L. Buchanan ..... Phillipsburg
First Vice-President, Louis S. Wegryn ..... Elizabeth
Second Vice-President, Carl N. Ware ..... Shiloh
Secretary, Marcus H. Greifinger ..... Newark
Treasurer, Daniel F. Featherston ..... Asbury Park

TRUSTEES

Luke A. Mulligan, *Chairman* (1962) ..... Leonia
Jerome G. Kaufman, *Secretary* (1961) ..... Newark
Jesse McCall ..... Newton
Ralph M. L. Buchanan ..... Phillipsburg
Louis S. Wegryn ..... Elizabeth
Carl N. Ware ..... Shiloh
Marcus H. Greifinger ..... Newark
Daniel F. Featherston ..... Asbury Park
F. Clyde Bowers ..... Mendham
David B. Allman (1962) ..... Atlantic City
John J. Bedrick (1963) ..... Bayonne
Nicholas A. Bertha (1962) ..... Wharton
C. Byron Blaisdell (1961) ..... Asbury Park
Louis K. Collins (1961) ..... Glassboro
Lloyd A. Hamilton (1962) ..... Lambertville
Frank J. Hughes (1963) ..... Gloucester
Joseph R. Jehl (1963) ..... Clifton
Samuel J. Lloyd (1963) ..... Trenton

COUNCILORS

First District (Union, Warren, Morris and Essex Counties) ..... Emanuel M. Satulsky, Elizabeth (1963)
Second District (Sussex, Bergen, Hudson and Passaic Counties) ..... John L. Olpp, Englewood (1962)
Third District (Mercer, Middlesex, Somerset and Hunterdon Counties) ..... Charles H. Calvin, Perth Amboy (1961)
Fourth District (Camden, Burlington, Ocean and Monmouth Counties) ..... E. Vernon Davis, Moorestown (1963)
Fifth District (Cape May, Cumberland, Atlantic, Gloucester and Salem Counties) ..... Isaac N. Patterson, Westville (1962)

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Delegates

C. Byron Blaisdell (1960) ..... Asbury Park
William F. Costello (1961) ..... Dover
Aldrich C. Crowe (1961 ..... Ocean City
J. Wallace Hurff (1960) ..... Newark
L. Samuel Sica (1960) ..... Trenton
Emer P. Weigel (1960) ..... Plainfield

Alternates

Ralph M. L. Buchanan (1960) ..... Phillipsburg
Joseph P. Donnelly (1961) ..... Jersey City
Elton W. Lance (1961) ..... Rahway
Jesse McCall (1960) ..... Newton
Herschel Pettit (1960) ..... Ocean City
John H. Rowland (1960) ..... New Brunswick

DELEGATES TO OTHER STATES

New York—William F. Costello (1961) ..... Dover
Connecticut—Lloyd A. Hamilton (1961) ..... Lambertville
New York—Levi M. Walker (1961) ..... Atlantic City
Connecticut—S. Eugene Dalton (1961) ..... Ventnor

OFFICERS OF SCIENTIFIC SECTIONS

Allergy

Aaron Weiner, *Chairman* ..... Fair Lawn
Frank H. Feldman, *Secretary* ..... Newark

Anesthesiology

Robert K. Egge, *Chairman* ..... Maplewood
Edward G. Bourns, *Secretary* ..... Westfield

Cardiovascular Diseases

Maurice N. Re, *Chairman* ..... Palisade
Joseph M. Stein, *Secretary* ..... Camden

Chest Diseases

Saul Lieb, *Chairman* ..... Newark
Thomas C. DeCecio, *Secretary* ..... Cliffside Park

Clinical Pathology

Milton H. Kannerstein, *Chairman* ..... Newark
Harry H. Stumpf, *Secretary* ..... Montclair

Dermatology

Benjamin B. Burrill, Jr., *Chairman* ..... Montclair
Sol. J. Fanburg, *Secretary* ..... Newark

Gastroenterology and Proctology

Samuel M. Gilbert, *Chairman* ..... Newark
Urban R. Finnerty, *Secretary* ..... Montclair

General Practice

A. Guy Campo, *Chairman* ..... Westville
George C. Parell, *Secretary* ..... Newark

Medicine

William D. Kimler, *Chairman* ..... Haddon Heights
William J. Snape, *Secretary* ..... Camden

Metabolism

Robert H. Areson, *Chairman* ..... Upper Montclair
John F. Hiner, *Secretary* ..... Titusville

Neuropsychiatry

William E. Ganss, *Chairman* ..... Plainfield
Ira S. Ross, *Secretary* ..... South Plainfield

Obstetrics and Gynecology

William H. Ainslie, *Chairman* ..... Metuchen
Douglas W. Payne, *Secretary* ..... Asbury Park

Ophthalmology

Louis A. Amdur, *Chairman* ..... Jersey City
Henry Abrams, *Secretary* ..... Princeton

Orthopedic Surgery

Arthur S. Thurm, *Chairman* ..... Trenton
James F. Collier, *Secretary* ..... Haddonfield

Otolaryngology

Myron J. Shapiro, *Chairman* ..... Newark
Arthur Dintenfass, *Secretary* ..... Atlantic City

Pediatrics

Samuel C. Southard, *Chairman* ..... Ventnor
Milton Prystowsky, *Secretary* ..... Belleville

Radiology

John J. Thompson, *Chairman* ..... Montclair
Nathan S. Deutsch, *Secretary* ..... Plainfield

Rheumatism

Jacob Heyman, *Chairman* ..... Newark
John J. Calabro, *Secretary* ..... Jersey City

Surgery

Eugene L. Watkins, *Chairman* ..... Morristown
Wayne W. Hall, *Secretary* ..... Paterson

Urology

Edward A. Brady, Jr., *Chairman* ..... New Brunswick
John C. Clark, *Secretary* ..... Asbury Park

STANDING COMMITTEES

Annual Meeting

Jerome G. Kaufman, *Chairman* (1962) ..... Newark
Edward E. Seidmon, *Vice-Chairman* (1961) ..... Plainfield
Milton Ackerman (1963) ..... Atlantic City
Raymond J. Gadek (1962) ..... Fords
Peter H. Marvel (1961) ..... Northfield
Herschel S. Murphy (1963) ..... Roselle

Subcommittee on Scientific Exhibits

Milton Ackerman, *Chairman* ..... Atlantic City
Robert L. Breckenridge ..... Camden
Louis K. Collins ..... Glassboro
Abraham J. Gitlitz ..... Tenafly
Thomas K. Rathmell ..... Trenton

Subcommittee on Scientific Program

Edward E. Seidmon, *Chairman* ..... Plainfield
(Chairmen and Secretaries of the Scientific Sections)

Credentials

Marcus H. Greifinger, *Chairman* (1961) ..... Newark
Eugene J. Tyrrell, *Vice-Chairman* (1961) .... Perth Amboy
William E. Bray (1961) ..... Pemberton
S. Thomas Camp (1963) ..... Westville
Charles P. Campbell (1962) ..... Hackensack
Elton W. Lance (1962) ..... Rahway
Raymond A. McCormack (1963) ..... Trenton

Finance and Budget

David B. Allman, *Chairman* (1962) ..... Atlantic City
Carl N. Ware, *Vice-Chairman* (1961) ..... Shiloh
Conrad M. Bahnson (1962) ..... Jersey City
Theodore K. Graham (1963) ..... Paterson
Francis A. Hauck (1961) ..... Sea Isle City
Samuel J. Lloyd (1963) ..... Trenton
Daniel F. Featherston, Treasurer, *Ex-Officio* .. Asbury Park

Honorary Membership

Aldrich C. Crowe, *Chairman* (1962) ..... Ocean City
Royal A. Schaaf, *Vice-Chairman* (1961) ..... Califon
Spencer T. Snedecor (1963) ..... Hackensack

Medical Defense and Insurance

Daniel F. Featherston, *Chairman* (1962) ..... Asbury Park
Benjamin F. Slobodien, *Vice-Chairman* (1961)..Perth Amboy
Ernest C. Hillman, Jr. (1963) ..... Newark
Elton W. Lance (1962) ..... Rahway
Frederick A. Mettler (1963) ..... Blairstown
William L. Palazzo (1962) ..... Teaneck
Marcus H. Greifinger, Secretary, *Ex-Officio* ..... Newark

Medical Education

Sherman Garrison, Jr., *Chairman* (1962) ..... Bridgeton
Morris H. Saffron, *Vice-Chairman* (1961) ..... Passaic
Louis F. Albright (1963) ..... Spring Lake
Malcolm M. Dunham (1961) ..... Woodbridge
Frank S. Forte (1962) ..... Newark
Donald C. Lynch (1963) ..... Trenton

Medical Student Loan Fund

Luke A. Mulligan, *Chairman* (1962) ..... Leonia
Vincent P. Butler, *Vice-Chairman* (1962) .... Jersey City
Louis K. Collins (1961) ..... Glassboro
John F. Kustrup (1961) ..... Trenton
George L. Nicoll (1963) ..... Dover

Publication

Fred B. Rogers, *Chairman* (1962) ..... Trenton
C. Spencer Davison, *Vice-Chairman* (1961) ..... Salem
Frank L. Rosen (1961) ..... Newark
Ralph M. L. Buchanan, President-Elect, *Ex-Officio* Phillipsburg
Marcus H. Greifinger, Secretary, *Ex-Officio* ..... Newark
Henry A. Davidson, Editor, *Ex-Officio* ..... Trenton

Revision of Constitution and Bylaws

Louis F. Albright, *Chairman* (1962) ..... Spring Lake
Joseph M. Gannon, *Vice-Chairman* (1962) ..... Plainfield
William E. Dodd (1961) ..... Beach Haven
Joseph C. Humbert (1963) ..... Stewartsville
John J. Thompson (1963) ..... Montclair
Robert E. Verdon (1961) ..... Cliffside Park
Marcus H. Greifinger, Secretary, *Ex-Officio* ..... Newark

Advisory to Woman's Auxiliary

Lewis C. Fritts, *Chairman* (1962) ..... Somerville
A. Guy Campo, *Vice-Chairman* (1961) ..... Westville
Ralph K. Bush (1962) ..... Merchantville
Kenneth E. Corson (1961) ..... Vineland
Volmar A. Mereschak 1963) ..... Phillipsburg
George O. Rowohlt (1963) ..... Dumont

ADMINISTRATIVE COUNCILS

Legislation

C. Byron Blaisdell, *Chairman* (1962) ..... Asbury Park
A. Guy Campo, *Vice-Chairman* (1961) ..... Westville
Christopher A. Beling (1963) ..... Montclair
William E. Bray (1962) ..... Pemberton
Sigmund C. Braunstein (1961) ..... West New York
Charles L. Cunniff (1962) ..... Jersey City
Winton H. Johnson (1963) ..... Hackensack
Samuel J. Lloyd (1961) ..... Trenton
John S. Madara (1963) ..... Salem
Leonard Rosenfeld (1961) ..... Ringoes
Ludwig L. Simon (1962) ..... Newark
James H. Spencer (1963) ..... Newton
Luke A. Mulligan, Chairman, Board of Trustees, *Ex-Officio* ..... Leonia

Medical Services

Irving Klompus, *Chairman* (1962) ..... Bound Brook
Nicholas E. Marchione, *Vice-Chairman* (1962) .... Vineland
Louis A. Amdur (1963) ..... Jersey City
Francis J. Benz (1962) ..... Chatham
Harry R. Brindle (1963) ..... Asbury Park
Durant K. Charleroy (1961) ..... Trenton
Frederick W. Durham (1962) ..... Haddonfield
Joseph M. Gannon (1961) ..... Plainfield
Raymond J. Germain (1963) ..... Lebanon
Donald B. Hull (1961) ..... Ridgewood
Charles B. Norton, Jr. (1963) ..... Woodstown
Andrew C. Ruoff, III (1961) ..... Pompton Plains
Ralph M. L. Buchanan, President-Elect, *Ex-Officio* Phillipsburg

Public Health

Robert S. Garber, *Chairman* (1962) ..... Belle Mead
John B. Fuhrmann, *Vice-Chairman* (1962) .... Flemington
Pascal J. Baiocchi (1961) ..... Newark
Jesse W. Carll (1963) ..... Bridgeton
John P. Coughlin (1963) ..... Jersey City
Anthony P. DeSpirito (1962) ..... Asbury Park
Elmer J. Elias (1961) ..... Trenton
Vincent H. Gillson (1961) ..... Westwood
Peter J. Guthorn (1963) ..... Asbury Park
Estelle T. Milliser (1962) ..... Westfield
Allen A. Parry (1961) ..... Madison
Gene N. Schraeder (1963) ..... Pleasantville
Louis S. Wegryn, First Vice-President, *Ex-Officio*..Elizabeth

Public Relations

John F. Kustrup, *Chairman* (1962) ..... Trenton
John J. Torppey, *Vice-Chairman* (1961) ..... Newark
Frederick W. Durham (1962) ..... Haddonfield
Gerard R. Gessner (1961) ..... New Brunswick
S. William Kalb (1962) ..... Newark
John E. McWhorter (1963) ..... Englewood
William P. Mulford (1961) ..... Beverly
Howard C. Pieper (1962) ..... Keyport
Aloysius P. Rieman (1963) ..... Jersey City
Paul H Steel (1963) ..... Atlantic City
Harry F. Suter (1961) ..... Penns Grove
Robert A. Weinstein (1963) ..... Newton
Carl N. Ware, Second Vice-President, *Ex-Officio*....Shiloh

SPECIAL COMMITTEES TO THE ADMINISTRATIVE COUNCIL ON MEDICAL SERVICES

Industrial Health

Willis B. Mitchell, *Chairman* ..... Toms River
Joseph Adamcik ..... Passaic
Ralph M. L. Buchanan ..... Phillipsburg
Delma W. Caldwell ..... Linden
George H. Huston, III ..... Bridgeton
Samuel I. Kooperstein ..... Jersey City
Arthur F. Mangelsdorff ..... Plainfield
Peter J. Norton ..... Trenton

Workmen's Compensation

Joseph A. Lepree, *Chairman* ..... Elizabeth
William J. D'Elia ..... Spring Lake
George A. Glass ..... Somerville
Robert V. Holman ..... Clifton
Michael J. Hyland ..... Newark
Andrew C. Ruoff, III ..... Pompton Plains
Henry S. Urbaniak ..... Trenton
Ralph A. Young ..... Linden
Joshua N. Zimskind ..... Trenton

SPECIAL COMMITTEES TO THE ADMINISTRATIVE COUNCIL ON PUBLIC HEALTH

Cancer Control

John L. Olpp, *Chairman* ..... Englewood
Conrad M. Bahnson ..... Jersey City
Nicholas A. Bertha ..... Wharton
David F. Bew ..... Northfield
William E. Bray ..... Pemberton
Benjamin Copleman ..... Perth Amboy
Frank F. Drews, Jr. ..... Englewood
George L. Erdman ..... Summit
Daniel F. Featherston ..... Asbury Park
Harry A. Reinhart ..... Vineland
Jacob M. Schildkraut ..... Trenton
Asher Yaguda ..... Newark

Child Health

Robert E. Jennings, *Chairman* ..... South Orange
Charles W. Burroughs ..... Trenton
Neil Castaldo ..... Cranford
Marshall F. Driggs ..... Englewood
William Greifinger ..... Newark
Phoebe Hudson ..... Westwood
Joseph R. Jehl ..... Clifton
David R. Lyons ..... East Orange
Martin A. Quirk ..... Red Bank
Theodore Schlossbach ..... Ocean Grove
Samuel C. Southard ..... Ventnor
Edward J. Thalheimer ..... Vineland

The Chronically Ill and the Aging

William H. Hahn, *Chairman* ..... Newark
Matthew E. Boylan ..... Jersey City
Thomas C. DeCecio ..... Cliffside Park
David Eckstein ..... Trenton
Ernest C. Hillman, Jr. ..... Newark
William D. Kimler ..... Haddon Heights
Rufus R. Little ..... Paramus
Laura E. E. Morrow ..... Passaic
Johannes F. Pessel ..... Trenton
Marion R. Stanford ..... Trenton
Abram L. Van Horn ..... Far Hills

Conservation of Hearing and Speech

S. Eugene Dalton, *Chairman* ..... Ventnor
Edgar P. Cardwell ..... Newark
Justus H. Cooley ..... Somerville
Edward F. Grueninger ..... Teaneck
Edward C. Jennings ..... Medford
Thomas H. McGlade ..... Camden
Albert F. Moriconi ..... Trenton
Morris Sherman ..... Bridgeton
James H. Spillane ..... Phillipsburg

Conservation of Vision

Samuel M. Diskan, *Chairman* ..... Atlantic City
Henry Abrams ..... Princeton
Edward A. Atwood ..... Paterson
Charles W. Boozan ..... Elizabeth
Vincent A. Burell ..... Phillipsburg
Alfonse A. Cinotti ..... Jersey City
Oram R. Kline, Jr. ..... Camden
Harry P. Landis, Jr. ..... Palmyra
Edwin M. Miller ..... Newton
Anthony M. Sellitto ..... South Orange
Ralph E. Siegel ..... Perth Amboy
John T. Worcester ..... Englewood

Maternal and Infant Welfare

John D. Preece, *Chairman* ..... Trenton
Mary Bacon ..... Bridgeton
Robert A. Cosgrove ..... Jersey City
Allan B. Crunden, Jr. ..... Montclair
Theodore K. Graham ..... Paterson
Theodore Loizeaux ..... Plainfield
B. Frank Lovett ..... Camden
Herschel S. Murphy ..... Roselle
Frank L. Paret ..... New Brunswick
Percy L. Smith ..... Trenton
Felix H. Vann ..... Englewood

Mental Health

John J. Mackin, *Chairman* ..... Jersey City
Harry Dicner ..... East Orange
James B. Goyne ..... Trenton
Evelyn P. Ivey ..... Morristown
Nicholas E. Marchione ..... Vineland
J. Lloyd Morrow ..... Passaic
Dorothy M. Rogers ..... Woodbury
George A. Rogers ..... Camden
Edward A. Schauer ..... Farmingdale
Martin H. Weinberg ..... Hammonton

Rehabilitation

Elmer J. Elias, *Chairman* ..... Trenton
E. Vernon Davis ..... Moorestown
Lewis C. Fritts ..... Somerville
George A. Glass ..... Somerville
Ralph Lev ..... Trenton
Carl A. Maxwell ..... Morristown
John M. Naame ..... Atlantic City
Robert J. Neville ..... Hackensack

SPECIAL COMMITTEES

Disaster Medical Services

R. Winfield Betts, *Chairman* ..... Medford
David B. Allman ..... Atlantic City
George E. Barbour ..... Somerville
Charles P. Campbell ..... Hackensack
Maurice B. Cohen ..... Wildwood
Sherman Garrison, Jr. ..... Bridgeton
Harry Halprin ..... Montclair
Jack R. Karel ..... Elizabeth
G. Albin Liva ..... Wyckoff
Albert F. Moriconi ..... Trenton
Frank L. Paret ..... New Brunswick
Carmine Pecora ..... Toms River

Physicians Placement Service

Samuel J. Lloyd, *Chairman* ..... Trenton
Marcus H. Greifinger ..... Newark
John S. Madara ..... Salem
John P. O'Connor ..... West Englewood
Howard C. Pieper ..... Keyport

Traffic Safety

A. M. K. Maldeis, *Chairman* ..... Camden
R. Winfield Betts ..... Medford
S. Eugene Dalton ..... Ventnor
Frederick G. Dilger ..... Hackensack
Harrison F. English ..... Trenton
John J. McGuire ..... Newark
William L. Sprout ..... Salem

OFFICIAL INTERMEDIARIES WITH NEW JERSEY SPECIALTY SOCIETIES

Aaron Weiner, N. J. *Allergy* Society ..... Fair Lawn

James R. Toombs, N. J. State Society of *Anesthesiologists* ..... Paterson

Saul Lieb, N. J. Chapter, American College of *Chest Physicians* ..... Newark

Duncan E. Hutcheon, N. J. Chapter, American Federation for *Clinical Research* ..... Jersey City

Hugh McCulloch, Jr., N. J. *Dermatological* Society ..... North Plainfield

Alfred E. Gras, N. J. *Diabetes* Association ..... Newark

Leo H. Siegel, N. J. *Gastroenterological* Society .... Newark

George C. Parell, N. J. Academy of *General Practice*..Newark

Mathilda R. Vaschak, The *Industrial* Medical Association of N. J. ..... New Brunswick

D. A. Mauriello, N. J. Society of *Internal Medicine* ..... Jersey City

Robert J. Mcarin, N. J. *Neuropsychiatric* Association ..... Montclair

Christopher T. Reilly, N. J. *Obstetrical and Gynecalagical* Society ..... Ridgewood

John Scillieri, N. J. Academy of *Ophthalmalogy and Otolaryngology* ..... Paterson

Edwin J. Otis, N. J. *Orthopaedic* Society .... Long Branch

George L. Erdman, N. J. Society of *Pathologists* .. Summit

Edward P. Duffy, Jr., N. J. Chapter, American Academy of *Pediatrics* ..... Belleville

Bertram M. Bernstein, N. J. Society for *Physical Medicine and Rehabilitation* ..... Trenton

James Edson, N. J. *Proctologic* Society ..... Paterson

Samuel A. Weiss, N. J. *Psychoanalytic* Society ..East Orange

Austin J. Tidaback, *Radiological* Society of N. J. .. Plainfield

Peter J. Warter, N. J. *Rheumatism* Association .... Trenton

Benjamin Daversa, N. J. Chapter, American College of *Surgeons* ..... Neptune

John L. Varriano, Society of *Surgeons* of N. J. .. Jersey City

---

COUNTY SOCIETY PRESIDENTS AND SECRETARIES

County	President	Secretary
Atlantic	Harvey N. Vandegrift, Ventnor	John W. Holland, Atlantic City
Bergen	George O. Rowohlt, Dumont	Charles P. Campbell, Hackensack
Burlington	Norman K. Boudwin, Beverly	R. Winfield Betts, Medford
Camden	I. Edward Ornaf, Camden	James G. Dickensheets, Camden
Cape May	Harold Fishman, Woodbine	Ulric J. Laquer, Cape May Court House
Cumberland	Alfred O. Davies, Millville	Frank J. T. Aitken, Bridgeton
Essex	Samuel W. Ebenfeld, East Orange	R. E. Remondelli, East Orange
Gloucester	Thomas F. Flynn, Jr., Woodbury	Francis M. Brower, III, Woodbury
Hudson	Charles A. Landshof, Jersey City	Clement M. Jones, Bayonne
Hunterdon	Carl W. Roessel, Flemington	John B. Fuhrmann, Flemington
Mercer	Peter J. Warter, Trenton	I. Frank Bird, Trenton
Middlesex	Stanley A. Gadek, Perth Amboy	Donald T. Akey, Metuchen
Monmouth	Merton F. Trippe, Asbury Park	Donald W. Bowne, Wanamassa
Morris	David P. Williams, Mountain Lakes	Adolph R. Wichman, Denville
Ocean	C. Norman Witte, Point Pleasant	Jesse Schuiman, Lakewood
Passaic	F. Albert Graeter, Paterson	Marion F. Kaletkowski, Paterson
Salem	Ford C. Spangler, Salem	George F. Reichwein, Penns Grove
Somerset	Nicholas G. Demy, Somerville	Howard Adler, Somerville
Sussex	Lester R. Eddy, Sussex	John J. Piampiano, Hamburg
Union	Carl G. Kapp, Elizabeth	Elbert H. Pogue, Elizabeth
Warren	Neumann C. Marlett, Belvidere	Ralph M. L. Buchanan, Phillipsburg

---

HALL-BROOKE HOSPITAL

An Active Treatment Hospital, located one hour from New York

Accredited by: The Central Inspection Board of the American Psychiatric Association
The Joint Commission on Accreditation of Hospitals

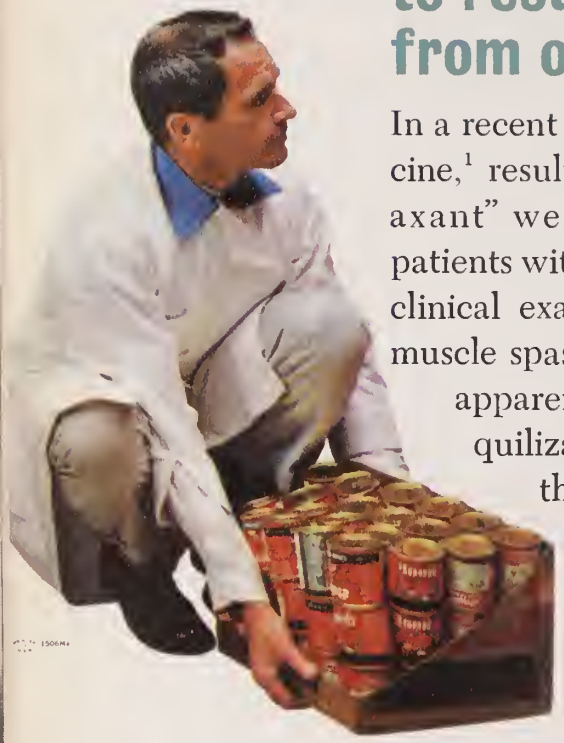
HALL-BROOKE, GREENS FARMS, BOX 31, CONN.

Telephone: WESTPORT CAPITAL 7-1251

George S. Hughes, M.D. — Robert Isenman, M.D.
Leo H. Berman, M.D. — John D. Marshall, Jr., M.D.
Albert M. Moss, M.D. — Edward M. Keelan, M.D.
Louis J. Micheels, M.D. — Peter P. Barbara, Ph.D.

Save a
family breadwinner
lost time from
LOW BACK PAIN
with
Trancopal®
Brand of chlormezanone
effective oral skeletal
muscle relaxant
and mild tranquilizer

Trancopal enables patients to resume their duties in from one to two days.



In a recent study of Trancopal in industrial medicine,[1] results from treatment with this "tranquil-axant" were good to excellent in 182 of 220 patients with muscle spasm or tension states. From clinical examination of those patients in whom muscle spasm was the main disorder, ". . . it was apparent that the combined effect of tranquilization and muscle relaxation enabled them to resume their normal duties in from twenty-four to forty-eight hours. . . . It is our clinical impression that Trancopal is the most effective oral skeletal muscle relaxant and mild tranquilizer currently available."[1] Side effects occurred in only 12 patients, and: "No patient required that the dosage be reduced to less than one Caplet three times daily because of intolerance."[1]

Clinical results with *Trancopal*®[1]

	Excellent	Good	Fair	Poor	Total
LOW BACK SYNDROMES					
Acute low back strain	25	19	8	6	58
Chronic low back strain	11	5	1	1	18
"Porters' syndrome"*	21	5	1	1	28
Pelvic fractures	2	1	—	—	3
NECK SYNDROMES					
Whiplash injuries	12	6	2	1	21
Torticollis, chronic	6	2	3	2	13
OTHER MUSCLE SPASM					
Spasm related to trauma	15	6	1	—	22
Rheumatoid arthritis	—	18	2	1	21
Bursitis	2	6	1	—	9
TENSION STATES	18	2	4	3	27
TOTALS	112 (51%)	70 (32%)	23 (10%)	15 (7%)	220 (100%

*Over-reaching in lifting heavy bags resulting in sprain of upper, middle, and lower back muscles.

Dosage: **Adults, 200 or 100 mg. orally three or four times daily.**
Relief of symptoms occurs in from fifteen to thirty minutes and lasts from four to six hours.

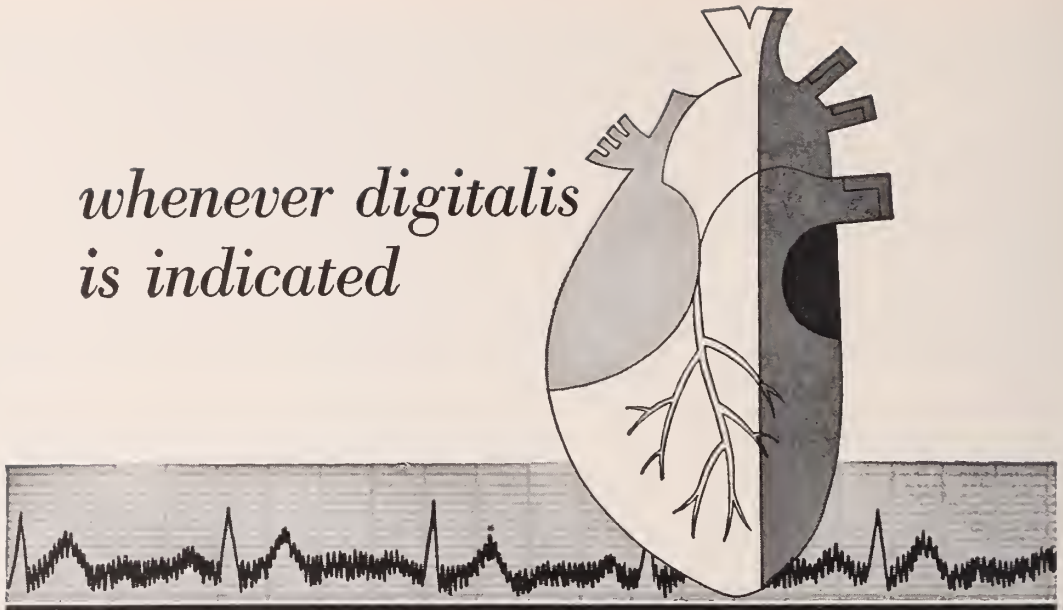
How Supplied: Trancopal Caplets®
200 mg. (green colored, scored), bottles of 100.
100 mg. (peach colored, scored), bottles of 100.

1. Kearney, R. D.: *Current Therap. Res.* 2:127, April, 1960.

1506M Trancopal (brand of chlormezanone) and Caplets, trademarks reg. U. S. Pat. Off.

Winthrop LABORATORIES, New York 18, N. Y

whenever digitalis is indicated



'LANOXIN'® brand DIGOXIN

formerly known as Digoxin 'B. W. & Co.'®

"If one digitalis agent were to be recommended for its adaptability to the many and varied clinical contingencies, we believe Digoxin would be the drug of choice."

Lown, B., and Levine, S. A.: Current Concepts in Digitalis Therapy, Boston, Little, Brown & Company, 1954, p. 23, par. 2.

'LANOXIN' TABLETS
0.25 mg. scored (white)
0.5 mg. scored (green)

'LANOXIN' INJECTION
0.5 mg. in 2 cc. (I.M. or I.V.)

'LANOXIN' ELIXIR PEDIATRIC
0.05 mg. in 1 cc.

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, N.Y.

THE NEW LIFE INSURANCE PLAN

officially endorsed by

THE MEDICAL SOCIETY OF NEW JERSEY

WHAT YOUR PLAN OFFERS

FIRST UNIT OF $10,000 of 5-year renewable and convertible term life insurance issued on a short health statement WITHOUT MEDICAL EXAMINATION, but subject to the company's underwriting rules of selection, PLUS as much as $40,000 additional life insurance subject to a physical examination.

PREMIUMS DO NOT CHANGE during each 5-year period.

RATES LOWER THAN you can obtain individually and guaranteed for the life of your policy with premiums reducible by dividends as declared by the company.

COVERAGE GUARANTEED non-cancellable even if you retire or move.

GUARANTEED RIGHT TO CONVERT to any permanent plan AT ANY TIME without evidence of insurability.

DOUBLE INDEMNITY for accidental death included without extra charge.

WAIVER OF PREMIUM for total and permanent disability prior to age 60 without extra charge.

MORE THAN 1,700 MEMBERS OF THE STATE SOCIETY ARE PRESENTLY INSURED UNDER THIS PROGRAM.

WHAT YOUR PLAN COSTS FOR EACH $10,000 UNIT

(Your age at the beginning of each five year term determines the premiums for each year during that term.)

YOUR AGE (nearest birthday)	ANNUAL	SEMI-ANNUAL
29 and under	$ 50.00	$ 25.50
30	60.00	30.60
31	63.00	32.10
32	65.00	33.20
33	67.00	34.20
34	70.00	35.70
35	73.00	37.20
36	77.00	39.30
37	80.00	40.80
38	83.00	42.30
39	87.00	44.40
40	90.00	45.90
41	93.00	47.40
42	96.00	49.00
43	99.00	50.50
44	103.00	52.50
45	107.00	54.60
46	113.00	57.60
47	124.00	63.20
48	136.00	69.40
49	148.00	75.50
50	160.00	81.60
51	175.00	89.30
52	185.00	94.40
53	195.00	99.50
54	205.00	104.60
55	230.00	117.30
56	250.00	127.50
57	265.00	135.20
58	280.00	142.80
59	295.00	150.50
60	315.00	160.70
61	330.00	168.30
62	345.00	176.00
63	360.00	183.60
64	375.00	191.30
65	405.00	206.60

Issued and renewed for successive 5 year terms beginning before 65th birthday. Insurance coverage then continuable through conversion.

Administered by:

E. & W. BLANKSTEEN AGENCY, INC.

75 Montgomery St., Jersey City 2, N. J. • Telephone: Delaware 3-4340

Underwritten by Nationwide Life Insurance Company of Columbus, Ohio

Highest rating in Best's Insurance Reports with more than 1½ billions of life insurance in force.

Carrying on congestion-free with fast-acting

NTZ®

NASAL SPRAY

At the first allergic sneeze, two inhalations from the **NTZ** Nasal Spray act speedily to bring exceptional relief of symptoms. The first spray shrinks the turbinates and enables the patient to breathe through his nose again. The second spray, a few minutes later, opens sinus ostia for essential ventilation and drainage. Excessive rhinorrhea is reduced. **NTZ** is well tolerated and provides safe "inner space" without causing chemical harm to the respiratory tissues.

NTZ is a balanced combination of three thoroughly evaluated compounds:

- **N** eo-Synephrine® **HCl, 0.5%** to shrink nasal membranes and sinus ostia and provide inner space
- **T** henfadil® **HCl, 0.1%** to provide powerful topical antiallergic action and lessen rhinorrhea
- **Z** ephiran® **Cl, 1:5000** (antibacterial wetting agent and preservative) to promote spread and penetration of the formula to less accessible nasal areas

NTZ is supplied in leakproof, pocket size, squeeze bottles of 20 cc. and in bottles of 30 cc. with dropper.

QUICK SYMPTOMATIC RELIEF OF HAY FEVER OR PERENNIAL RHINITIS

NTz, Neo-Synephrine (brand of phenylephrine), Thenfadil (brand of thenyldiamine) and Zephiran (brand of benzalkonium, as chloride, refined), trademarks reg. U. S. Pat. Off.

Winthrop
LABORATORIES
New York 18, N. Y.

GONORRHEA *IS ON THE MARCH AGAIN...*

a new timetable for recovery:

only six capsules of TETREX can cure a male patient with gonorrhea in *just one day

Tetrex®

U.S.PAT.NO.2,791,609

THE ORIGINAL TETRACYCLINE PHOSPHATE COMPLEX

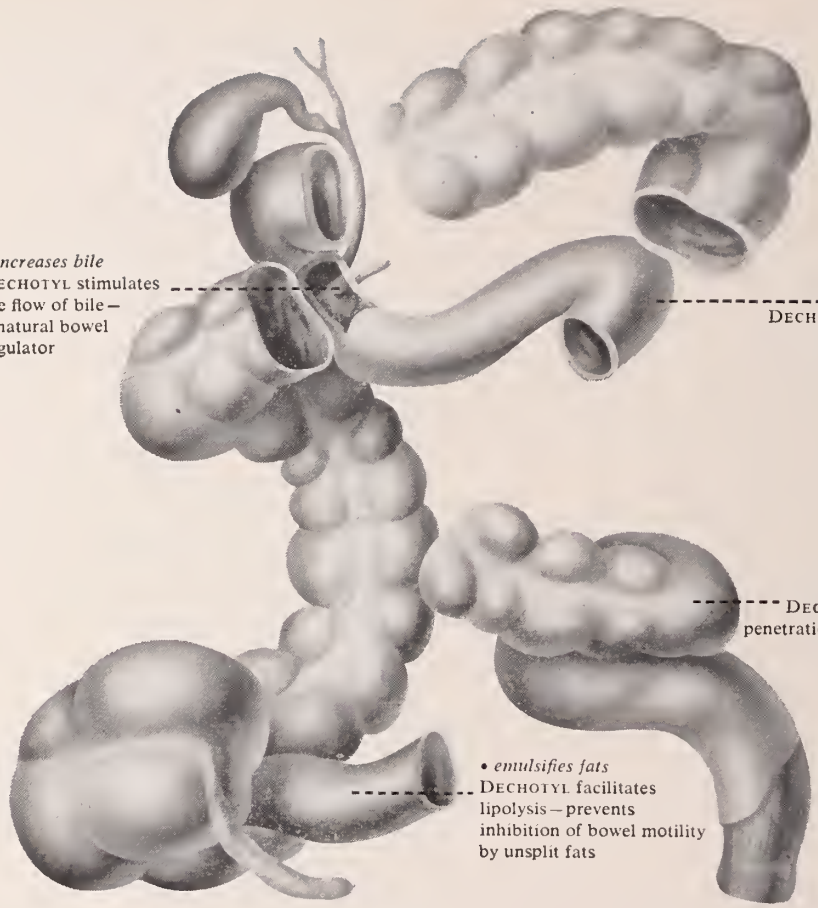
TETREX CAPSULES. 250 mg. Each capsule contains: TETREX (tetracycline phosphate complex equivalent to tetracycline HCl activity) — 250 mg.

DOSAGE: Gonorrhea in the male — Six capsules of TETREX in 3 divided doses, in one day.

* Marmell, M., and Prigot, A.: Tetracycline phosphate complex in the treatment of acute gonococcal urethritis in men. Antibiotic Med. & Clin. Ther. 6:108 (Feb.) 1959.

BRISTOL

BRISTOL LABORATORIES,
SYRACUSE, NEW YORK



helps free your patient from both...
constipation and laxatives

DECHOTYL®

TRABLETS*

well tolerated...gentle transition to normal bowel function

Recommended to help convert the patient—naturally and gradually—to healthy bowel habits. Regimens of one week or more are suggested to assure maintenance of normal rhythm and to avoid the repetition of either laxative abuse or constipation.

Average adult dose: Two TRABLETS at bedtime as needed or as directed by a physician. *Action usually is gradual, and some patients may need 1 or 2* TRABLETS *3 or 4 times daily.*

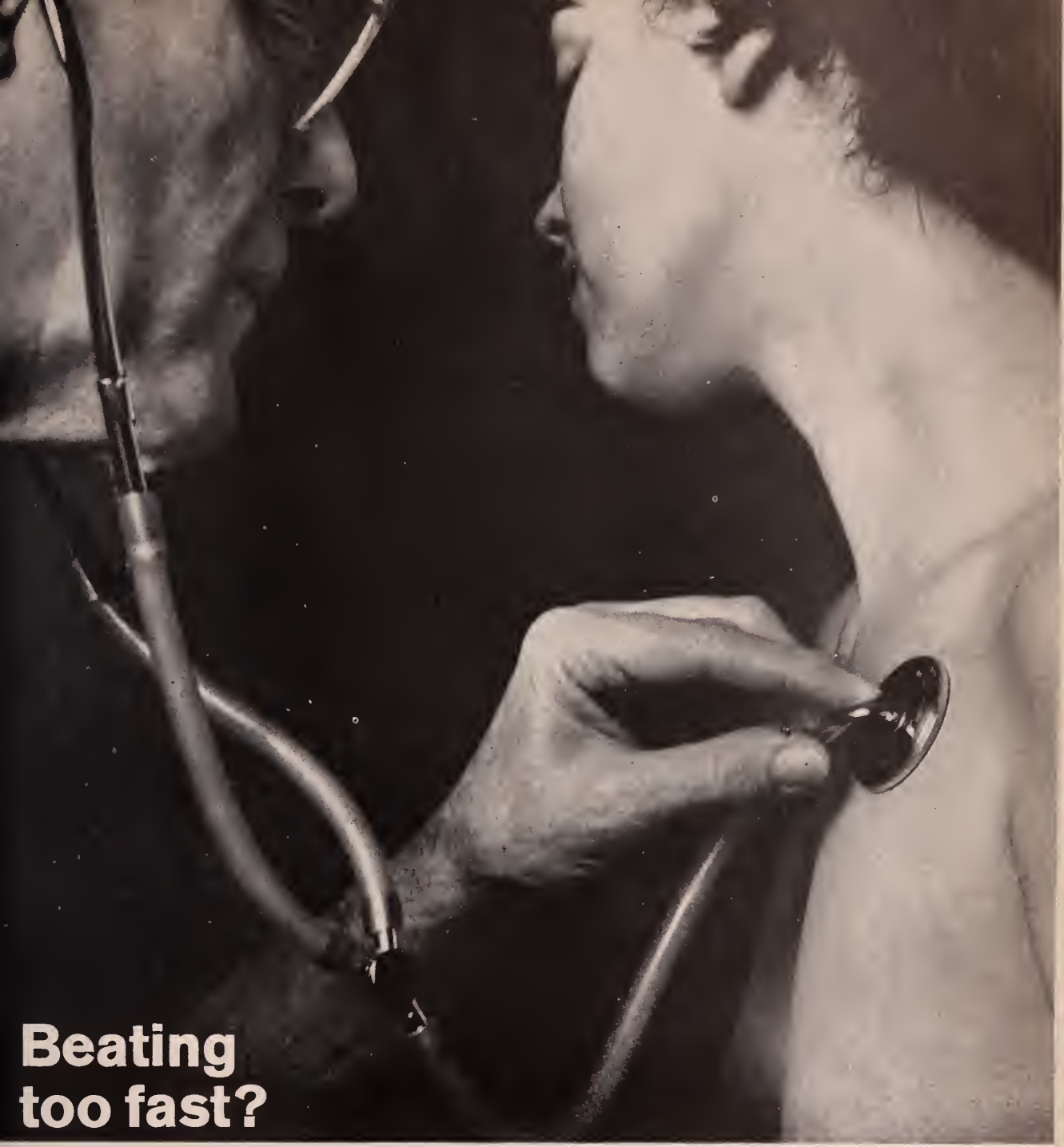
Contraindications: Biliary tract obstruction; acute hepatitis.

DECHOTYL TRABLETS provide 200 mg. DECHOLIN,® (dehydrocholic acid, AMES), 50 mg. desoxycholic acid, and 50 mg. dioctyl sodium sulfosuccinate, in each trapezoid-shaped, yellow TRABLET. Bottles of 100.

*AMES T.M. for trapezoid-shaped tablet.

AMES
COMPANY, INC
Elkhart • Indiana
Toronto • Canada

84160



Slow it down with SERPASIL®

(reserpine CIBA)

Serpasil has proved effective as a heart-slowing agent in the following conditions: mitral disease; myocardial infarction; cardiac arrhythmias; neurocirculatory asthenia; thyroid toxicosis; excitement and effort syndromes; cardiac neurosis; congestive failure. Serpasil should be used with caution in patients receiving digitalis and quinidine. It is not indicated in cases of aortic insufficiency.

SUPPLIED: Tablets, 0.1 mg., 0.25 mg. (scored) and 1 mg. (scored). Complete information available on request.

CIBA
SUMMIT • NEW JERSEY

STEREO WEBCOR

WEBCOR REGENT CORONET STEREO HI-FI TAPE RECORDER **$329.95**

- Will record and play back both stereo and monaural tapes
- Provides 2-channel and 4-channel stereo playback
- Dual-channel 16-watt amplifier
- Self-contained Stereo system with 2 Hi-Fi Speakers
- 2 directional microphones
- In ebony with silver trim

Model 2007

Available at all

DEPT. STORES AND BETTER MUSIC, RECORD, CAMERA AND APPLIANCE DEALERS

Write for catalog to Exclusive N. J. Wholesale Distributors

ALL-STATE DISTRIBUTORS,

INCORPORATED

457 CHANCELLOR AVENUE - WAverly 3-4900 - NEWARK, N. J.

The physician listens to a tense, nervous patient discuss her emotional problems. To help her, he prescribes Meprospan (400 mg.), the only continuous-release form of meprobamate.

The patient takes one Meprospan-400 capsule at breakfast. She has been suffering from recurring states of anxiety which have no organic etiology.

She stays calm while on Meprospan, even under the pressure of busy, crowded supermarket shopping. And she is not likely to experience any autonomic side reactions, sleepiness or other discomfort.

She takes another capsule of Meprospan-400 with her evening meal. She has enjoyed sustained tranquilization all day—and has had no between-dose letdowns. Now she can enjoy sustained tranquilization all through the night.

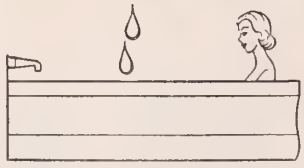
Relaxed, alert, attentive . . . she is able to listen carefully to P.T.A. proposals. For Meprospan does not affect either her mental or her physical efficiency.

Peacefully asleep . . . she rests, undisturbed by nervousness or tension. (Literature on Meprospan is available from Wallace Laboratories, Cranbury, N. J.)

for **dryness** and **itching,** prickly heat and rash
intertrigo, insect bites, other summer skin discomforts

Sardo®

in the bath



1. Spoor, H. J.: N. Y. State J. Med., Oct. 15, 1958

SARDO acts promptly to help restore needed natural oil and moisture[1] to dry, itchy skin, by helping to re-establish the normal lipid-aqueous balance. Thus SARDO eases irritation, soothes, softens, brings sustained comfort.

USED IN THE BATH, SARDO releases millions of microfine water-dispersible globules* to provide an emollient suspension which enhances your other therapy . . . in prickly heat, intertrigo, insect bites, skin dryness and itch of atopic dermatitis, eczematoid dermatitis, senile pruritus, soap dermatitis, etc.[1]

Patients appreciate pleasant, convenient, easy-to-use SARDO. Non-sensitizing. Most economical. Bottles of 4, 8 and 16 oz.

Write for *Samples* and literature . . .

Sardeau, Inc. 75 East 55th Street New York 22, New York

© 1959 *Patent Pending, T. M.

when pressure is a problem

Reduce pressure through bradycardic, tranquillizing action....

'Rauwistan'

the MRT-standardized Rauwolfia

BECAUSE its unique chemical and biological standardization assures uniformity and consistency of effect time after time with high activity and minimal incidence of side effects.

SUPPLIED: Tablets of 50 and 100 mg., in bottles of 100.

DOSAGE: 100 to 300 mg. daily, in divided doses.

Reduce pressure through bradycardic, tranquillizing plus direct hypotensive action....

'Verwolfia'

the MRT-standardized Rauwolfia-Veratrum

BECAUSE it adds to Rauwistan the specific hypotensive effect of uniquely standardized Veratrum and assures uniformity and consistency of effect time after time with high activity and minimal incidence of side effects.

SUPPLIED: 50 mg. of Rauwolfia serpentina and of Veratrum viride (standardized whole root) in each tablet; in bottles of 50 and 100.

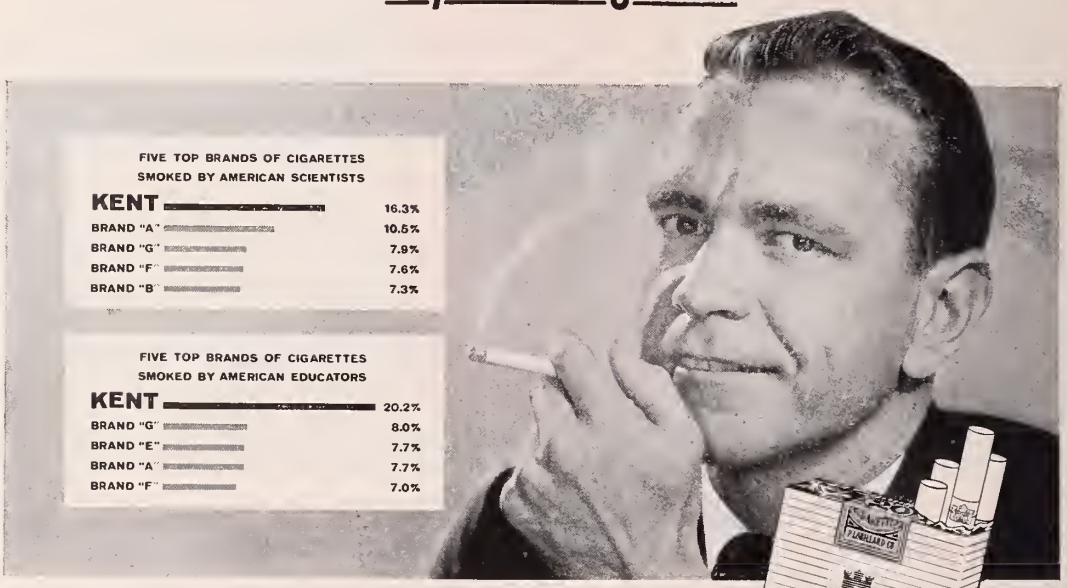
DOSAGE: 1 to 3 tablets daily for the first 2 or 3 days; then 1 or 2 tablets daily, as required.

MRT *M. R. Thompson, Inc.* Cranford, N. J.

ALL OVER AMERICA!

KENT with the MICRONITE FILTER IS SMOKED BY MORE SCIENTISTS and EDUCATORS

than any other cigarette!*



THIS does not constitute a professional endorsement of Kent. But these men, like millions of other Kent smokers, smoke for pleasure, and choose their cigarette accordingly.

The rich pleasure of smoking Kent comes from the flavor of the world's finest natural tobaccos, and the free and easy draw of Kent's famous Micronite Filter.

KING-SIZE, REGULAR-SIZE OR CRUSH-PROOF BOX

If you would like the booklet, "The Story of Kent", for your own use, write to: P. Lorillard Company—Research Department, 200 East 42nd Street, New York 17, New York.

For good smoking taste, it makes good sense to smoke KENT

* Results of a continuing study of cigarette preferences, conducted by O'Brien Sherwood Associates, N.Y., N.Y.

A PRODUCT OF P. LORILLARD COMPANY · FIRST WITH THE FINEST CIGARETTES · THROUGH LORILLARD RESEARCH

© 1960, P. LORILLARD CO.

CLINICAL REMISSION IN A "PROBLEM" ARTHRITIC

In rheumatoid arthritis with diabetes mellitus. A 54-year-old diabetic with a four-year history of arthritis was started on DECADRON, 0.75 mg./day, to control severe symptoms. After a year of therapy with 0.5 to 1.5 mg. daily doses of DECADRON, she has had no side effects and diabetes has not been exacerbated. She is in clinical remission.*

New convenient b.i.d. alternate dosage schedule: the degree and extent of relief provided by DECADRON allows for b.i.d. maintenance dosage in many patients with so-called "chronic" conditions. Acute manifestations should first be brought under control with a t.i.d. or q.i.d. schedule.

Supplied: As 0.75 mg. and 0.5 mg. scored, pentagon-shaped tablets in bottles of 100. Also available as Injection DECADRON Phosphate. Additional information on DECADRON is available to physicians on request. DECADRON is a trademark of Merck & Co., Inc.

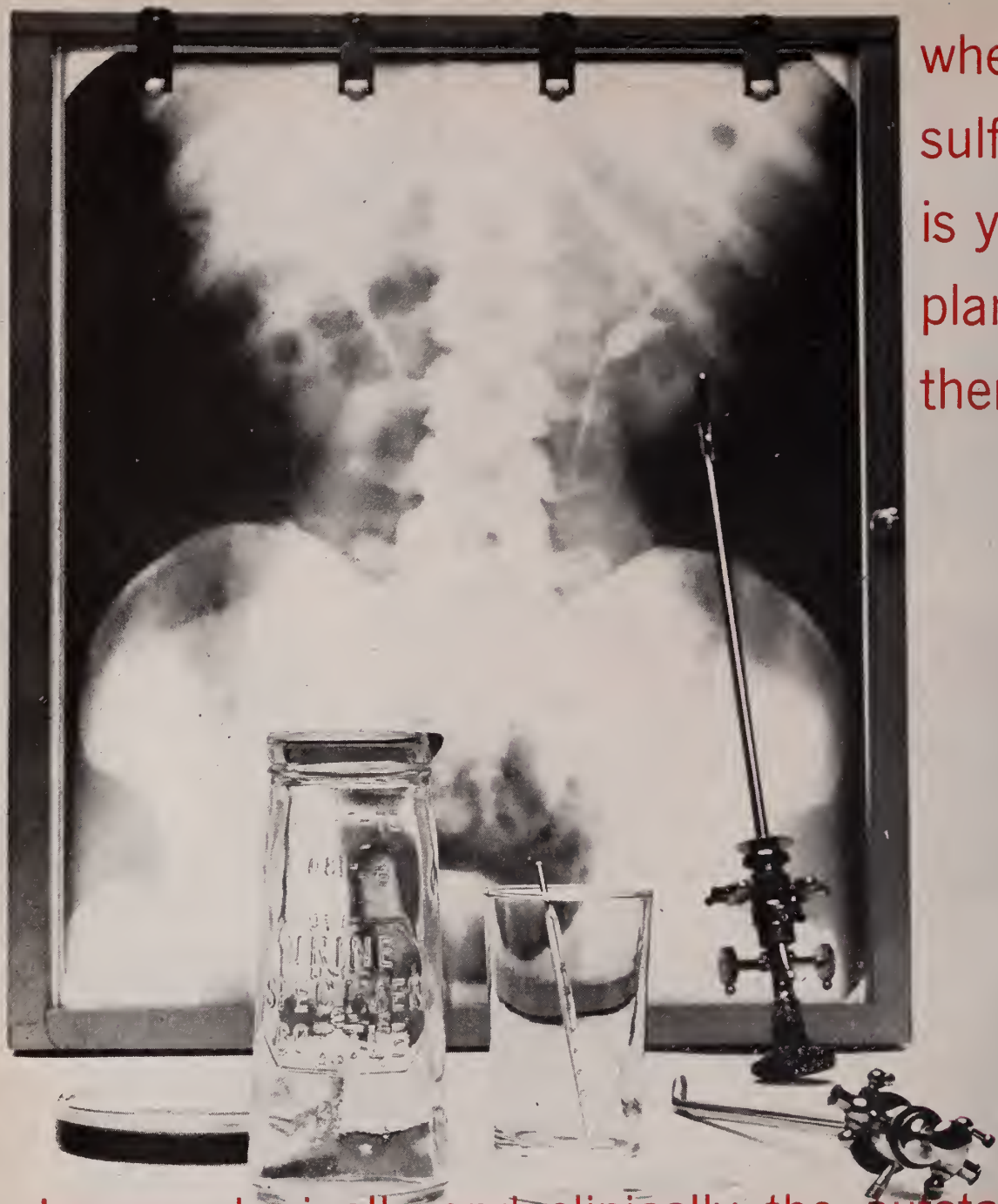
*From a clinical investigator's report to Merck Sharp & Dohme.

Decadron®

Dexamethasone

TREATS MORE PATIENTS MORE EFFECTIVELY

MSD MERCK SHARP & DOHME • Division of Merck & Co., Inc., West Point, Pa.



when sulfa is your plan of therapy..

pharmacologically and clinically the outstanding

Rapid peak attainment — for early control — KYNEX® Sulfamethoxypyridazine reaches peak plasma levels in 1 to 2 hours[1,2] . . . or approximately one-half the time of other once-a-day sulfas.[2] Uninterrupted control is then sustained over 24 hours with the single daily dose . . . through slow excretion without renal alteration.

High free levels — for dependable control — More efficient absorption delivers a higher percentage of sulfamethoxypyridazine — averaging 20 per cent greater at respective peaks than glucuronide-conversion sulfas.[2] Of the total circulating levels, 95 per cent remains in the fully active, unconjugated form even after 24 hours.[3]

Extremely low toxicity[4] . . . only 2.7 per cent incidence in recommended dosage — Typical of KYNEX relative safety, toxicity studies[5] in 223 patients showed TOTAL side effects (both subjective and objective) in only six cases, all temporary and rapidly reversed. Another evaluation[4] in 110 patients confirmed the near-absence of reactions when given at the recommended dosage. High solubility of both free and conjugated product[6] obviates renal complications. No crystalluria has been reported.

Successful against these organisms: streptococci, staphylococci, E. coli, A. aerogenes, paracolon bacillus, Gram-negative rods, pneumococci, diphtheroids, Gram-positive cocci and others.

1. Boger, W. P.; Strickland, C. S., and Gylfe, J. M.: Antibiotic Med. & Clin. Ther. 3:378, (Nov.) 1956. 2. Boger, W. P.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 48. 3. Sheth, U. K.; Kulkarni, B. S., and Kamath, P. G.: Antibiotic Med. & Clin. Ther. 5:604 (Oct.) 1958. 4. Vinnicombe, J.: Ibid. 5:474 (July) 1958. 5. Anderson, P. C., and Wissinger, H. A.: U. S. Armed Forces M. J. 10:1051 (Sept.) 1959. 6. Roepke, R. R.; Maren, T. H., and Mayer, E.: Ann. New York Acad. Sc. 60:457 (Oct.) 1957.

once-a-day sulfa . . .

NOTE: Investigators note a tendency of some patients to misinterpret dosage instructions and take KYNEX on the familiar q.i.d. schedule. Since one KYNEX tablet is equivalent to eight to twelve tablets of other sulfas, even moderate overdosage may produce side effects. Thus, the single dose schedule must be stressed to the patient.

KYNEX Tablets, 0.5 Gm., bottles of 24 and 100. Dosage: Adults, 0.5 Gm. (1 tablet) daily, following an initial first day dose of 1 Gm. (2 tablets).

KYNEX Acetyl Pediatric Suspension, cherry-flavored, 250 mg. sulfamethoxypyridazine activity per teaspoonful (5 cc.). Bottles of 4 and 16 fl. oz. Recommended Dosage: Children under 80 lbs.: 1 teaspoonful (250 mg.) for each 20 lb. body weight, the first day, and ½ teaspoonful per 20 lb. per day thereafter. For children 80 lbs. and over: 4 teaspoonfuls (1.0 Gm.) initially and 2 teaspoonfuls daily thereafter. Give immediately after a meal.

KYNEX®

Sulfamethoxypyridazine Lederle

NEW—for acute G.U. infection AZO-KYNEX® Phenylazodiaminopyridine HCl—Sulfamethoxypyridazine Tablets, contains 125 mg. KYNEX in the shell with 150 mg. phenylazodiaminopyridine HCl in the core. Dosage: 2 tablets q.i.d. the first day; 1 tablet q.i.d. thereafter.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

THE ORIGINAL potassium phenethicillin

SYNCILLIN

(POTASSIUM PENICILLIN-152)

higher peak blood levels orally
than with oral penicillin V or intramuscular penicillin G

A dosage form to meet the individual requirements of patients of all ages in home, office, clinic, and hospital:

Syncillin Tablets—250 mg. . . . Syncillin Tablets—125 mg.

Syncillin for Oral Solution—60 ml. bottles—when reconstituted 125 mg. per 5 ml.

Syncillin Pediatric Drops —1.5 Gm. bottles. Calibrated dropper delivers 125 mg.

Complete information on indications, dosage and precautions is included in the official circular accompanying each package.

BRISTOL LABORATORIES, SYRACUSE, NEW YORK

BRISTOL

she calls it "nervous indigestion"

diagnosis: a wrought-up patient with a functional gastro-intestinal disorder compounded by inadequate digestion. **treatment:** reassurance first, then medication to relieve the gastric symptoms, calm the emotions, and enhance the digestive process. **prescription:** new Donnazyme—providing the multiple actions of widely accepted Donnatal® and Entozyme®—two tablets t.i.d., or as necessary.

Each Donnazyme tablet contains
—In the gastric-soluble outer layer: Hyoscyamine sulfate, 0.0518 mg.; Atropine sulfate, 0.0097 mg.; Hyoscine hydrobromide, 0.0033 mg.; Phenobarbital (⅛ gr.), 8.1 mg.; and Pepsin, N. F., 150 mg. **In the enteric-coated core:** Pancreatin, N. F., 300 mg., and Bile salts, 150 mg.

ANTISPASMODIC - SEDATIVE - DIGESTANT

DONNAZYME

A. H. ROBINS COMPANY, INCORPORATED • RICHMOND 20, VIRGINIA

Naturetin

Squibb Benzydroflumethiazide

Naturetin c̄ K

Squibb Benzydroflumethiazide with Potassium Chloride

"...a safe and extraordinarily effective diuretic..."[1]

Naturetin — reliable therapy in edema and hypertension — maintains a favorable urinary sodium-potassium excretion ratio . . . retains a balanced electrolytic pattern:

"...the increase in urinary output occurs promptly..."[1]

"...the least likely to invoke a negative potassium balance..."[2]

"...a dose of 5 mg. of Naturetin produces a maximal sodium loss."[2]

"...an effective diuretic agent as manifested by the loss in weight..."[3]

"...no apparent influence of clinical importance on the serum electrolytes or white blood count."[3]

"...no untoward reactions were attributed to the drug."[4]

Although Naturetin causes the least serum potassium depletion as compared with other diuretics, supplementary potassium chloride in Naturetin c̄ K provides added protection when treating hypokalemia-prone patients; in conditions where likelihood of electrolyte imbalance is increased or during extended periods of therapy.

Numerous clinical studies confirm the effectiveness[1-15] of Naturetin as a diuretic and antihypertensive — usually in dosages of 5 mg. per day.

■ the most potent diuretic, mg. for mg.—more than 100 times as potent as chlorothiazide ■ prolonged action — in excess of 18 hours ■ maintains its efficacy as a diuretic and antihypertensive even after prolonged or increased dosage use ■ convenient once-a-day dosage — more economical for patients ■ low toxicity — few side effects—low sodium diets not necessary ■ not contraindicated except in complete renal shutdown ■ *in hypertension*—significant lowering of the blood pressure. Naturetin may be used alone or with other antihypertensive drugs in lowered doses.

Supplied: Naturetin Tablets, 5 mg. (scored) and 2.5 mg. Naturetin c̄ K (5 c̄ 500) Tablets (capsule-shaped) containing 5 mg. benzydroflumethiazide and 500 mg. potassium chloride. Naturetin c̄ K (2.5 c̄ 500) Tablets (capsule-shaped) containing 2.5 mg. benzydroflumethiazide and 500 mg. potassium chloride.

SQUIBB

Squibb Quality—the Priceless Ingredient

References: 1. David, N. A.; Porter, G. A., and Gray, R. H.: Monographs on Therapy **5**:60 (Feb.) 1960. 2. Stenberg, E. S., Jr.; Benedetti, A., and Forsham, P. H.: Op. cit. **5**:46 (Feb.) 1960. 3. Fuchs, M.; Moyer, J. H., and Newman, B. E.: Op. cit. **5**:55 (Feb.) 1960. 4. Marriott, H. J. L., and Schamroth, L.: Op. cit. **5**:14 (Feb.) 1960. 5. Ira, G. H., Jr.; Shaw, D. M., and Bogdonoff, M. D.: North Carolina M. J. **21**:19 (Jan.) 1960. 6. Coben, B. M.: M. Times, to be published. 7. Breneman, G. M., and Keyes, J. W.: Henry Ford Hosp. M. Bull. **7**:281 (Dec.) 1959. 8. Forsham, P. H.: Squibb Clin. Res. Notes **2**:5 (Dec.) 1959. 9. Larson, E.: Op. cit. **2**:10 (Dec.) 1959. 10. Kirkendall, W. M.: Op. cit. **2**:11 (Dec.) 1959. 11. Yu, P. N.: Op. cit. **2**:12 (Dec.) 1959. 12. Weiss, S.; Weiss, J., and Weiss, B.: Op. cit. **2**:13 (Dec.) 1959. 13. Moser, M.: Op. cit. **2**:13 (Dec.) 1959. 14. Kahn, A., and Greenblatt, I. J.: Op. cit. **2**:15 (Dec.) 1959. 15. Grollman, A.: Monographs on Therapy **5**:1 (Feb.) 1960.

'NATURETIN' IS A SQUIBB TRADEMARK.

in rheumatic disorders

whenever aspirin proves inadequate

Sterazolidin®

brand of prednisone-phenylbutazone

Even in the more transient rheumatic disorders, an anti-inflammatory effect more potent than that provided by aspirin is often desirable to hasten recovery and get the patient back to work.
By combining the anti-inflammatory action of prednisone and phenylbutazone, Sterazolidin brings about exceptionally rapid resolution of inflammation with relief of symptoms and restoration of function.
Since Sterazolidin is effective in low dosage, the possibility of significant hypercortisonism, even in long-term therapy, is substantially reduced.

Availability: Each Sterazolidin® capsule contains prednisone 1.25 mg.; Butazolidin®, brand of phenylbutazone, 50 mg.; dried aluminum hydroxide gel 100 mg.; magnesium trisilicate 150 mg.; and homatropine methylbromide 1.25 mg. Bottles of 100 capsules.

Geigy, Ardsley, New York

Geigy

165-60

PROVEN . . . MILLIONS USED . . . effectively

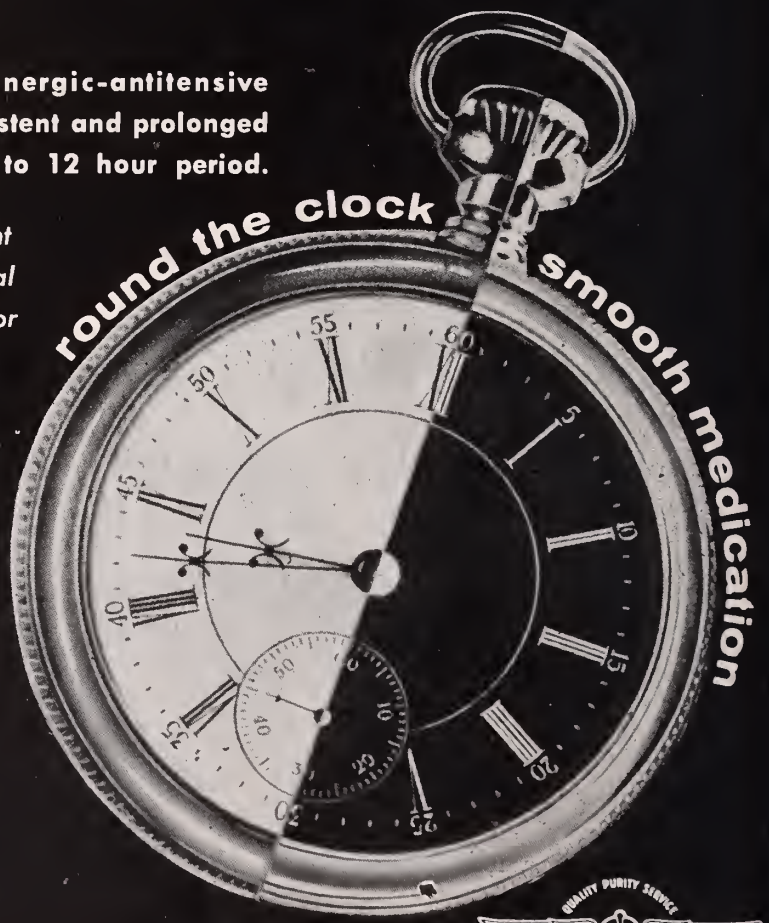
for Spastic Tension States

SED-TENS TY-MED*

RELAXES THE SPASTIC G. I. TRACT RELIEVES NAUSEA IN PREGNANCY

Provides superior anticholinergic-antitensive action through smooth, consistent and prolonged release of drugs over a 10 to 12 hour period.

The rate of release is independent of location in the gastrointestinal system—the same rate in ***ACID*** *or* ***ALKALINE*** *media.*



DOSAGE: One tablet morning and night.

Each Ty-Med* tablet contains:

Amobarbital	50 mg.
Homatropine Methylbromide	7.5 mg.

*LEMMON Brand of timed-release medication.

A clinical supply of SED-TENS Ty-Med tablets is available from . . .

LEMMON PHARMACAL CO.
Sellersville, Pa.

QUALITY PURITY SERVICE
LEMMON PHARMACAL COMPANY

CONSISTENTLY GOOD CLINICAL RESULTS IN TRICHOMONAL AND MONILIAL VAGINITIS

TRICOFURON IMPROVED (Suppositories and Powder) cured 143 of 161 patients with vaginitis due to Trichomonas vaginalis, Candida (Monilia) albicans, or both. "Almost immediate symptomatic improvement was noted with the first insufflation."

Criteria for cure: freedom from infecting organisms as well as symptoms on repeated examinations during a three-month follow-up. This cure rate of 88.8% is "surprisingly similar" to results reported by earlier investigators.

Coolidge, C. W.; Glisson, C. S., and Smith, A. S.: J.M.A. Georgia 48:167, 1959.

TRICOFURON®

IMPROVED

2-step treatment brings swift relief, eradicates stubborn trichomonads, Candida (Monilia) albicans, Hemophilus vaginalis

1. **POWDER** for weekly insufflation in your office. MICOFUR®, brand of nifuroxime, 0.5% and FUROXONE®, brand of furazolidone, 0.1% in an acidic water-dispersible base.

2. **SUPPOSITORIES** for continued home use —1st week one suppository in the morning and one on retiring. After 1st week, one suppository at night may suffice.

Continue use of suppositories during menses. Treatment should be continued throughout a complete menstrual cycle and for several days thereafter. MICOFUR 0.375% and FUROXONE 0.25% in a water-miscible base.

Rx new box of 24 suppositories with applicator for more practical and economical therapy. Also available: box of 12 suppositories with applicator.

NITROFURANS—a *unique* class of antimicrobials

EATON LABORATORIES, NORWICH, NEW YORK

Lifts depression...

You see an improvement within a few days
Thanks to your prompt treatment and the smooth action of Deprol, her depression is relieved and her anxiety and tension calmed – *often in a few days.* She eats well, sleeps well and soon returns to her normal activities.

as it calms anxiety!

Smooth, balanced action lifts depression as it calms anxiety... rapidly and safely

Balances the mood — no "seesaw" effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient —*they often aggravate anxiety and tension.*

And although amphetamine-barbiturate combinations may counteract excessive stimulation—*they often deepen depression.*

In contrast to such "seesaw" effects, Deprol's smooth, *balanced* action lifts depression as it calms anxiety—both at the same time.

Acts swiftly — the patient often feels better, sleeps better, within a few days. Unlike the delayed action of most other antidepressant drugs, which may take two to six weeks to bring results, Deprol relieves the patient quickly — often within a few days. Thus, the expense to the patient of long-term drug therapy can be avoided.

Acts safely — no danger of liver damage. Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function—frequently reported with other antidepressant drugs.

Bibliography *(13 clinical studies, 858 patients)*: **1.** Alexander, L. (35 patients): Chemotherapy of depression – Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. **2.** Bateman, J. C. and Carlton, H. N. (50 patients): Meprobamate and benactyzine hydrochloride (Deprol) as adjunctive therapy for patients with advanced cancer. Antibiotic Med. & Clin. Therapy 6:648, Nov. 1959. **3.** Beerman, H. M. (44 patients): The treatment of depression with meprobamate and benactyzine hydrochloride. Western Med. 1:10, March 1960. **4.** Bell, J. L., Tauber, H., Santy, A. and Pulito, F. (77 patients): Treatment of depressive states in office practice. Dis. Nerv. System 20:263, June 1959. **5.** Breitner, C. (31 patients): On mental depressions. Dis. Nerv. System 20:142, (Section Two), May 1959. **6.** Gordon, P. E. (50 patients): Deprol in the treatment of depression. Dis. Nerv. System 21:215, April 1960. **7.** Landman, M. E. (50 patients): Clinical trial of a new antidepressive agent. J. M. Soc. New Jersey. In press, 1960. **8.** McClure, C. W., Papas, P. N., Speare, G. S., Palmer, E., Slattery, J. J., Kanefal, S. H., Henken, B. S., Wood, C. A. and Ceresia, G. B. (128 patients): Treatment of depression – New technics and therapy. Am. Pract. & Digest Treat. 10:1525, Sept. 1959. **9.** Pennington, V. M. (135 patients): Meprobamate-benactyzine (Deprol) in the treatment of chronic brain syndrome, schizophrenia and senility. J. Am. Geriatrics Soc. 7:656, Aug. 1959. **10.** Rickels, K. and Ewing, J. H. (35 patients): Deprol in depressive conditions. Dis. Nerv. System 20:364, (Section One), Aug. 1959. **11.** Ruchwarger, A. (87 patients): Use of Deprol (meprobamate combined with benactyzine hydrochloride) in the office treatment of depression. M. Ann. District of Columbia 28:438, Aug. 1959. **12.** Settel, E. (52 patients): Treatment of depression in the elderly with a meprobamate-benactyzine hydrochloride combination. Antibiotic Med. & Clin. Therapy 7:28, Jan. 1960. **13.** Splitter, S. R. (84 patients): Treatment of the anxious patient in general practice. J. Clin. & Exper. Psychopath. In press, April-June 1960.

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate. **Supplied:** Bottles of 50 light-pink, scored tablets. Write for literature and samples.

Deprol®

WALLACE LABORATORIES/*New Brunswick, N. J.*

CP-2139

NEW

the physician-requested addition to the DONNAGEL family

DONNAGEL®-PG

Donnagel with paregoric equivalent

for better control of acute nonspecific diarrheas...

Robins

This pleasant-tasting combination of two outstanding antidiarrheals—DONNAGEL and paregoric—delivers more comprehensive relief with greater certainty in acute self-limiting diarrheas.

Each 30 cc. (1 fluidounce) of DONNAGEL-PG contains:

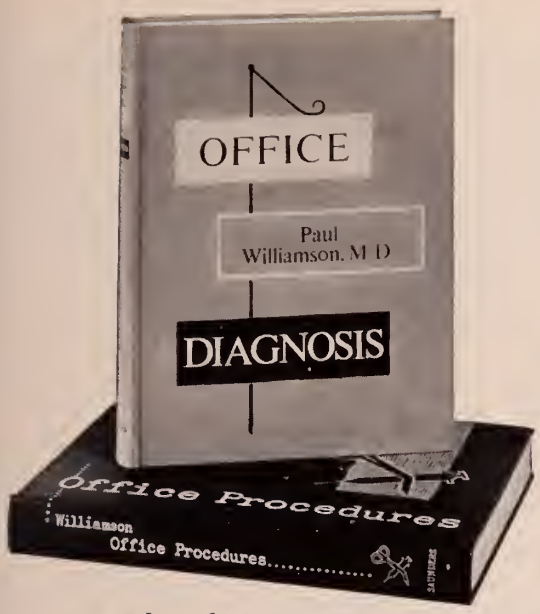
Powdered opium U.S.P.	*Kaolin*	*Pectin*	*Natural belladonna alkaloids*	*Phenobarbital*
24.0 mg. (equivalent to paregoric 6 ml.)	6.0 Gm.	142.8 mg.	hyoscyamine sulfate 0.1037 mg. atropine sulfate 0.0194 mg. hyoscine hydrobromide 0.0065 mg.	($\frac{1}{4}$ gr.) 16.2 mg.
Diminishes propulsive contractions and tenesmus; makes fecal matter less liquid	Adsorbent and demulcent action binds toxins and irritants; protects intestinal mucosa	Demulcent action complements effect of kaolin	Antispasmodic action reduces intestinal hypermotility; minimizes the risk of cramping	Mild sedative action lessens tension

Supplied: Banana flavored suspension in bottles of 6 fl. oz.

Also available: DONNAGEL® with NEOMYCIN — for control of bacterial diarrheas.
DONNAGEL® — the basic formula — when paregoric or an antibiotic is not required.

A. H. ROBINS CO., INC., Richmond 20, Virginia

Making today's medicines with integrity . . . seeking tomorrow's with persistence



2 Companion Volumes
by Paul Williamson, M. D.

Office Diagnosis

New! Written from the author's long experience in general practice, this book offers sound, ready-to-use advice on solving the family physician's daily diagnostic problems. With the help of simple line illustrations, Dr. Williamson informally details those diagnostic techniques that can be performed right in your own office.

97 important signs and symptoms are discussed. Beginning with symptomatic evidence, the author takes you back to its possible causes to help you arrive more easily at a tenable diagnosis. You will find symptoms such as *headache, hypertension, papular rash, anorexia, cough, cyanosis, heart murmurs, constipation, incontinence, pain in the breasts, leukorrhea* clearly covered. Where pertinent, Dr. Williamson offers definitive help on: etiology, history taking, general examination of the patient, x-ray, laboratory tests, drug therapy, diagnostic pitfalls to avoid, complications, etc.

If you are familiar with *Williamson's Office Procedures* (below), you know the kind of useful, down-to-earth help to expect from this new volume.

By PAUL WILLIAMSON, M.D. 470 pages, 8" x 11", with 350 illustrations. $12.50. *New!*

Office Procedures

Dr. Williamson fully discusses 379 useful management procedures for 171 common disorders and diseases in this unusual book. Aided by crystal clear illustrations, he tells you exactly how to best proceed with those techniques that can be safely and effectively performed in your own office. You will find precise descriptions of: how to irrigate the ear; how to pack for nosebleed; how to construct and fit a truss in inguinal hernia; how to treat muscle tears and ruptures; how to retrieve a retracted tendon; how to properly incise and drain a breast abscess; etc.

By PAUL WILLIAMSON, M.D. 412 pages, 8" x 11", with 1100 illustrations. $12.50. *Published 1955.*

New (2nd) Edition!

Frederick and Towner—The Office Assistant in Medical Practice

This handy manual will save you time and money in training an efficient office assistant. It is packed with help on every phase of her job—as *receptionist, secretary, nurse, bookkeeper* and *technician.*

These are the kind of problems on which your assistant will find valuable help: *What should you say in a series of collection letters?* How do you keep a narcotics inventory? *What should you remember in preparing the doctor's bag?* To whom do the patient's medical records belong? *How do you sharpen a hypodermic needle?* How do you prepare a patient for pelvic examination? etc.

The authors have brought this new edition fully up-to-date. The chapter on *Bookkeeping* is expanded with many new illustrations on the "write-it-once" bookkeeping system, etc. The chapter on *Instruments* is now much more detailed and clearly illustrated. Much new help is added on sterilization.

By PORTIA M. FREDERICK, Instructor, Medical Office Assisting, Long Beach City College; and CAROL TOWNER, Director of Special Services, Communications Division, American Medical Association. 407 pages, 5¾" x 8", illustrated. $5.25. *New (2nd) Edition!*

Order from **W. B. SAUNDERS COMPANY**—West Washington Sq., Phila. 5

Please send me the following books and charge my account:

☐ Williamson's Office Diagnosis, $12.50 ☐ Williamson's Office Procedures, $12.50

☐ Frederick & Towner's The Office Assistant, $5.25

Name.....

Address..... SJG-860

when she's not like herself anymore

Metalex® basic in the care of the aging

when body tone, mental and sensory faculties begin to fade—*she's irritable, confused, forgetful, apathetic*

when voices begin to fade—*in loss of auditory acuity, in tinnitus*

when vision begins to dim—*in loss of visual acuity, in loss of peripheral vision*

℞ Metalex® *cerebral stimulant / vasodilator*

The stimulant—pentylenetetrazol—facilitates cerebral and reflex nerve activity.

The vasodilator—nicotinic acid—augments blood and oxygen supply to vital areas—

Thus, METALEX increases body tone and aids mental and sensory faculties.

Composition: Each teaspoonful (5 ml.) of the Elixir and each Tablet contains: Pentylenetetrazol 100 mg., Nicotinic Acid 50 mg.

Dosage: One or two teaspoonfuls of the Elixir or one or two Tablets four times a day—one-half hour before meals and before bedtime.

Available: Elixir: Pint and Gallon bottles. Tablets: Bottles of 100 and 1000.

References: 1. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics, 2nd Ed., New York, Macmillan Company, 1955. 2. O'Reilly, P. O., Demay, M. and Kotlowski, K.: Cholesteremia and Nicotinic Acid. A.M.A. Arch. Int. Med. 100:797-801 (Nov.) 1957.

STORCK Pharmaceuticals, Inc.,
2326 Hampton Blvd., St. Louis 10, Mo.

— eases and speeds the return to normal bowel function —

The comprehensive antidiarrheal formula af Pamalín brings positive relief to patients with specific and nanspecific diarrheas, bacillary dysentery, nonspecific ulcerative colitis and enteric disturbances induced by amtibiotics.

Pectin and kaolin pratect against mechanical irritation, adsorb toxins and bacteria, and consalidate fluid stools. Sulfaguanidine concentrates antibacterial actian in the enteric tract. Opium tincture suppresses excessive peristalsis and reduces the defecation reflex.

Each palatable 15 cc. (tablespoon) contains:

Sulfaguanidine U.S.P.	2 Gm.
Pectin N.F.	0.225 Gm.
Kaolin	3 Gm.
Opium tincture U.S.P.	0.08 cc.
(equivalent to 2 cc. of paregaric)	

Dosage

ADULTS: Initially 1 or 2 tablespoons from four to six times doily, or 1 or 2 teaspaans after eoch loose bowel movement; reduce dasage as diorrhea subsides.

CHILDREN: ½ teaspoon (2.5 cc.) per 15 pounds of body weight every faur hours doy and night until stools are reduced ta five doily, then every eight hours for three days.

HOW SUPPLIED: Battles of 16 fl. oz.

Exempt narcotic.
Available on prescription only.

Filter Queen actually traps–and holds–the minute particles found in tobacco smoke!

ter Queen proves it with the dramatic smoke test. A ter Queen vacuum cleaner is placed inside an air-tight ar, plastic dome which is then filled with smoke—smoke dense the Filter Queen can barely be seen. Then, the ter Queen is turned on.

In only four seconds all traces of smoke have completely nished!

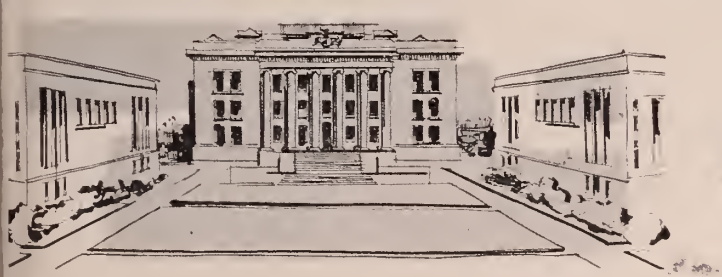
This is possible thanks to Filter Queen's remarkable tented Sanitary Filter Cone. Makes it ideal for hospital d home use where dust control is so vital. Air is exhausted a circular pattern near the top of the unit, thus eliminat-

The cleaning ability of Filter Queen is unsurpassed. A permanently lubricated, precision-built one HP motor i the heart of Filter Queen's cleaning ability. Its Cycloni Action assures sustained peak suction power. And accord ing to a recent article in the Journal of the America Medical Association,* Filter Queen was described, withou reservation, as the *quietest* of all vacuum cleaners tested Another plus for hospital and home use.

Filter Queen sanitation system is built to last—to giv years of dependable service even under extreme conditions

pped!

ıanufacturer—your assurance of quality. That's another
ɜason why so many hospitals now use Filter Queen.
We urge you to investigate Filter Queen. You'll find a
istributor listed in the Yellow Pages.



Harvard Medical School.

lter Queen Home Sanitation System is used by
ıe Harvard Medical School, and in many other
ading scientific and industrial institutions.

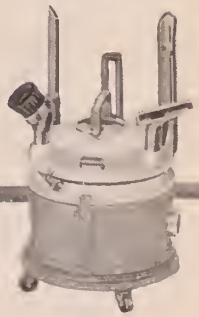
Today's Health

REPLACEMENT OR REFUND OF MONEY
Guaranteed by Good Housekeeping
IF NOT AS ADVERTISED THEREIN

LISTED UNDER RECLAMATION SERVICE
UL
UNDERWRITERS' LABORATORIES INC.

FILTER QUEEN

HOME SANITATION SYSTEM



A PRODUCT OF HEALTH-MOR, INC., Chicago 1, Illinois

*Copies available from Professional Dept., Health-Mor, Inc., 203 N. Wabash Ave., Chicago 1, Illinois

Another significant statement concerning the role of fats

FREE: *Wesson recipes, available in quantity for your patients, show how to prepare meats, seafoods, vegetables, salads and desserts with poly-unsaturated vegetable oil. Request quantity needed from The Wesson People, Dept. N, 210 Baronne St., New Orleans 12, La.*

Dietary Linoleic Acid and Linoleate—*Effects in Diabetic and Nondiabetic Subjects with and without Vascular Disease*

A paper by Laurance W. Kinsell, M.D., et al., excerpted from Diabetes—The Journal of the American Diabetes Association, May-June 1959

••*Linoleic acid as the major 'hypocholesterolemic agent' in vegetable fats.* The question has been raised as to the mechanism of lowering of the plasma lipids by a variety of vegetable fats. Among the entities present in or absent from vegetable fat which have been considered are: (a) the absence of cholesterol; (b) the presence of certain vegetable sterols; (c) the presence of certain vegetable phospholipids; (d) the nature of one or more of the fatty acids present; (e) the presence of trace materials.

in the diet

The absence of cholesterol has been excluded as a major factor.[5a] Phospholipids, if they contain a sufficient quantity of unsaturated fatty acids may produce a striking reduction. In our experience thus far saturated phospholipids fail to produce such an effect.[7]

Beveridge and his associates believe that vegetable sterols, particularly beta-sitosterol, are responsible to a significant degree for the cholesterol-lowering effect.[8] In our experience the vegetable sterols have a relatively weak and unpredictable effect of this sort.

Since the fatty acids of animal fats are predominantly saturated, and the fatty acids of most vegetable fats are predominantly polyunsaturated, with linoleic acid as the major component of the vegetable fats which lower cholesterol and other lipids, the question arises whether linoleic acid per se is capable of lowering plasma lipids. As reported previously[7] this is indeed the case. In a recent study in a young male with peripheral atherosclerosis in association with elevation of plasma cholesterol and of total lipids, ethyl linoleate produced a greater fall in the plasma lipid levels than had moderate amounts of natural sources of unsaturated fat. Linoleic acid, therefore, appears to be the most important single lipid-lowering component of vegetable fat.

* * *

Significantly higher levels of cholesterol were observed during oleate administration than during administration of equal amounts of linoleate. The relatively low cholesterol values during the second oleate period may have been related to linoleate stored in fat depots. The fatty acid composition of the cholesterol esters reflected the fat which was fed, i.e., the mono-enoic† acid content averaged more than 40 per cent during oleate feeding and less than 20 per cent during linoleate ingestion. Essentially, a mirror image of this resulted during linoleate feeding, at which time di-enoic acid predominated.

* * *

The data presented in this paper appear to establish that linoleic acid administered either as purified ethyl ester or as naturally occurring fat, in sufficient quantity, in properly constructed diets, will reduce plasma lipids to normal levels. The amount of linoleic acid required appears to bear a direct relationship to the amount of saturated fat included in the diet. Linoleic acid requirement may also bear a significant relationship to the amount of atherosclerosis present.

The transition from evaluation of the effect of dietary entities upon plasma lipids, to the evaluation of the effect of such materials upon vascular disease is difficult. However, such evaluation is not impossible. The requisites are adequate measuring sticks and well-controlled studies of sufficient duration. The duration of observation of effects of unsaturated fat in diabetic and nondiabetic patients with vascular disease is in no instance more than five years, and in the majority of instances, less than three. Our present impression is that improvement has occurred in some patients with atherosclerosis and with diabetic retinal and renal disease which was more than we would have anticipated in terms of the natural course of the disease. However, since it is well known that major fluctuations in these diseases can occur in individuals receiving no treatment, we believe it is appropriate at this time to say that no untoward effects appear to result when one prescribes diets containing large amounts of unsaturated fat for patients with such diseases, and it is not impossible that beneficial effects may be associated with such diets.••

* * *

5a Kinsell, L.W., Partridge, J. W., Boling, L., Margen, S., and Michaels, G.D.: Dietary modification of serum cholesterol and phospholipid levels. J. Clin. Endocrinol and Met. 12:909, 1952.

7 Kinsell, L. W., Friskey, R., Splitter, S., Michaels, G. D.: Essential fatty acids, lipid metabolism, and atherosclerosis. Lancet 1:334, 1958.

8 Beveridge, J.M., Connell, W.F., Firstbrook, J. B., Mayer, G.A., and Wolfe, M.J.: Effects of certain vegetable and animal fats on plasma lipids of humans. J. Nutrition 56:311, 1955.

† Mono-enoic (mono-unsaturated) acid is presumably synonymous under these conditions with oleic acid and di-enoic (di-unsaturated) acid with linoleic acid

Where a vegetable (salad) oil is medically recommended for a cholesterol depressant regimen, Wesson is unsurpassed by any readily available brand.

WESSON'S IMPORTANT CONSTITUENTS

Wesson is 100% cottonseed oil . . . winterized and of selected quality	
Linoleic acid glycerides (poly-unsaturated)	50-55%
Oleic acid glycerides (mono-unsaturated)	16-20%
Total unsaturated	70-75%
Palmitic, stearic and myristic glycerides (saturated)	25-30%
Phytosterol (predominantly beta sitosterol)	0.3-0.5%
Total tocopherols	0.09-0.12%
Never hydrogenated—completely salt free	

PRESCRIPTION PHARMACISTS

TO THE MEMBERS OF

The Medical Society of New Jersey

PLACE	NAME AND ADDRESS	TELEPHONE
BELLEVILLE	Joralemon Pharmacy, 531 Joralemon St.	PLym'th 9-4535-9858
BERGENFIELD	Horn's Pharmacy, 475 So. Washington Ave.	DUmont 4-1119
BERGENFIELD	Merit Pharmacy, 8 So. Washington Ave.	DUmont 4-9844
BOONTON	Preston Drugs, Del's Village Shopping Center	DEerfield 4-3466
BOUND BROOK	Lloyd's Drug Store, 305 East Main St.	ELliot 6-0150
BUTLER	Pink's Pharmacy, 178 Main St.	BUtler 9-0090, 9-1063
CLIFTON	Fleischner's Pharmacy, 652 Allwood Road	PRescott 7-6689
CLOSTER	Mid Town Pharmacy, 237 Closter Dock Road	CLoster 5-0070
DOVER	Leslie's Drugs, Inc., 9 East Blackwell St.	FOxcroft 6-1405
DUMONT	Lenrow's Pharmacy Inc., 10 W. Madison Ave.	DUmont 4-0842-1500
EDISON TOWNSHIP	Walter's Pharmacy, 1034 Amboy Ave.	LIberty 8-2614
EMERSON	Emerson Pharmacy, 201 Kinderkamack Road	COlfax 2-4999
FLEMINGTON	Green's Pharmacy, 52 Main St.	FLemington 108
FORDS	Fords Pharmacy, Inc., 550 New Brunswick Ave.	HIllcrest 2-4568
GLOUCESTER	King's Pharmacy, Broadway and Market Sts.	GLouc't'r 6-0781-8970
HAWTHORNE	Melcon's Pharmacy, 207 Diamond Bridge Ave.	HAwthorne 7-1546
HIGHLANDS	Highlands Pharmacy, 148 Bay Ave.	HIghlands 3-1058
JERSEY CITY	The Cole Pharmacy, Inc., 710 Grand St.	Delaware 3-9294
JERSEY CITY	J. B. Feinberg Pharmacy, 659 Newark Ave.	OLdfield 3-6376
JERSEY CITY	Honiberg Drug & Surgical Supply Co., 618 Newark Ave.	SWarthmore 8-6700
JERSEY CITY	Lauria's Pharmacy, 768 West Side Ave.	HEnderson 3-1519
JERSEY CITY	S. Taube Inc., 250 Jackson Ave.	HEnd'rs'n 3-2606-0642
JERSEY CITY	Waters Pharmacy, 492 Jackson Ave.	DElaware 3-3043
KEYPORT	Sav-On-Drugs, J. Meisler, opp. Post Office	COlfax 4-0904
LAKEWOOD	Alpert's Pharmacy, 224 Clifton Ave., Cor. 3rd St.	FOxcroft 3-3600
LITTLE FALLS	Swisher Pharmacy, Inc., 94 Main St.	CLifford 6-0835
METUCHEN	Wernik's Pharmacy, 412 Main St.	LIberty 8-0123
MILLTOWN	Milltown Pharmacy, 21 No. Main St.	MIlltown 8-0081
MILLVILLE	Richard H. Knowles Pharmacy, 600 No. High St.	TAylor 5-0721
MOORESTOWN	Stiles' Pharmacy, 75 East Main St.	BElmont 5-0088
MORRISTOWN	Carrell's Pharmacy (N. E. Corrao, Pharm.) 31 South St.	JEfferson 9-0143
MORRISVILLE, PA.	Pryor's Pharmacy, Bridge St. & Penna. Ave.	CYpress 5-7416
MOUNT HOLLY	Goldy's Pharmacy, Main & Washington Sts.	AMherst 7-2250
MOUNT HOLLY	Mount Holly Pharmacy, 64 Main St.	AMherst 7-0453
NEWARK	Marquier's Pharmacy, Sanford & So. Orange Aves.	ESsex 3-7721
NEWARK	Smith's Pharmacy, 315 So. Orange Ave.	MArket 3-1514

(Continued on following page)

PRESCRIPTION PHARMACISTS

TO THE MEMBERS OF

The Medical Society of New Jersey

(Continued from preceding page)

NEW BRUNSWICK	Bode Drug Co., 120 French St.	KIlmer 5-2676
NEW BRUNSWICK	Hoagland's Drug Store, 365 George St.	KIlmer 5-0048
NEW BRUNSWICK	Rutgers Pharmacy, 429 Livingston Ave.	CHarter 9-6666
NEW BRUNSWICK	Tobin's Drug Store, 335 George St.	CHarter 9-0780
NEW BRUNSWICK	Zajac's Pharmacy, 225 George St.	KIlmer 5-0582
OCEAN CITY	Selvagn's Pharmacy, 862 Asbury Ave.	OCean CIty 3535
OLD BRIDGE	Old Bridge Pharm., Inc., Englishtown Rd. & 7th St.	CLifford 4-5454
ORANGE	Highland Pharmacy, 536 Freeman St.	ORange 3-1040
ORANGE	Hollywood Pharmacy, 49 Central Ave.	ORange 5-1752
PASSAIC	Wollman Pharmacy, 143 Prospect St.	PRescott 9-0081
PATERSON	Vallario's Pharmacy, 357 Totowa Ave.	ARmory 4-2139
PAULSBORO	Nastase's Pharmacy, 762 Delaware St.	PAulsboro 8-1569
PERTH AMBOY	Jacobs' Drug Store, 434 Amboy Ave.	VAlley 6-3273
PITMAN	Lodge's Pharmacy, 39 So. Broadway	LUther 9-2392
PRINCETON	The Thorne Pharmacy, 168 Nassau St.	WAlnut 4-0077
RAHWAY	Kirstein's Pharmacy, 74 East Cherry St.	RAhway 7-0235
RIDGEFIELD PARK	Lloyd's Prescriptions, 209 Main St.	DIamond 2-8383
RIDGEWOOD	Davis Pharmacy, Inc., 2 Wilsey Square	OLiver 2-2444
ROCKAWAY	Leslie's Drugs, Inc., 36 West Main St.	OAkwood 7-5544
RUMSON	Rumson Pharmacy, W. E. Fogelson	RUmson 1-1234
SHREWSBURY	Shrewsbury Pharmacy, 570 Broad St.	SHadyside 1-4874
SOMERDALE	Balaban's Pharmacy, Maiden Lane & White Horse Pike	STerling 3-2956
SOUTH AMBOY	Madura Pharmacy, 115 N. Broadway	PArkway 1-1732
SOUTH ORANGE	Taft's Pharmacy, 2 South Orange Ave.	SOuth Orange 2-0063
TRENTON	Adams & Sickles, State & Prospect Sts.	OWen 5-6396
TRENTON	Delahanty's Pharmacy, State St. at Chambers	EXport 3-4261
TRENTON	Episcopo's Pharmacy, Chambers & Liberty Sts.	EXport 3-3017
TRENTON	Foy's Drug Store, 3024 So. Broad St.	EXport 3-2367
TRENTON	H. S. Hughes, Thatcher Pharmacy, 401 Hudson St.	EXport 2-5616
TRENTON	Kehr's Pharmacy, A. F. Capriotti, R. P., M.P.A.	OWen 5-6807
TRENTON	Lee's Sun Ray Pharmacy, 940 Parkway Ave.	TUxedo 2-3456
UNION	Perkins Union Center Pharmacy	MUrdock 6-0877
UNION CITY	Husni's Pharmacy, 2503 Bergenline Ave.	UNion 5-2577
UNION CITY	Jos. Parentini's Pharmacy, Inc., Charles H. Arnoldi	UNion 7-4806
VENTNOR	Barsky Drugs, Inc., 5217 Atlantic Ave.	ATlantic City 2-1177
WEST NEW YORK	The Owl Pharmacy, 6611 Bergenline Ave.	UNion 5-0384
WEST ORANGE	West Orange Pharmacy, 443 Main St.	ORange 4-9824
WOODBURY	Resnick's So. Broad Pharmacy, 305 So. Broad St.	TIlden 5-0647
WRIGHTSTOWN	Bowen's Pharmacy, 152 Fort Dix Road	RAymond 3-2176

FOUND: a dependable solution to

"the commonest gynecologic office problem"

"VULVOVAGINITIS, CAUSED BY TRICHOMONAS VAGINALIS, CANDIDA ALBICANS, Haemophilus vaginalis, or other bacteria, is still the commonest gynecologic office problem . . . cases of chronic or mixed infection are often extremely difficult to cure." Among 75 patients with vulvovaginitis caused by one or more of these pathogens, TRICOFURON IMPROVED cleared symptoms in 70; virtually all were severe, chronic infections which had persisted despite previous therapy with other agents. "Permanent cure by both laboratory and clinical criteria was achieved in 56. . . . "

Ensey, J. E.: Am. J. Obst. 77:155, 1959

TRICOFURON®

Improved

- Swiftly relieves itching, burning, malodor and leukorrhea
- Destroys Trichomonas vaginalis, Candida (Monilia) albicans, Haemophilus vaginalis
- Achieves clinical and cultural cures where others fail
- Nonirritating and esthetically pleasing

2 steps to lasting relief:

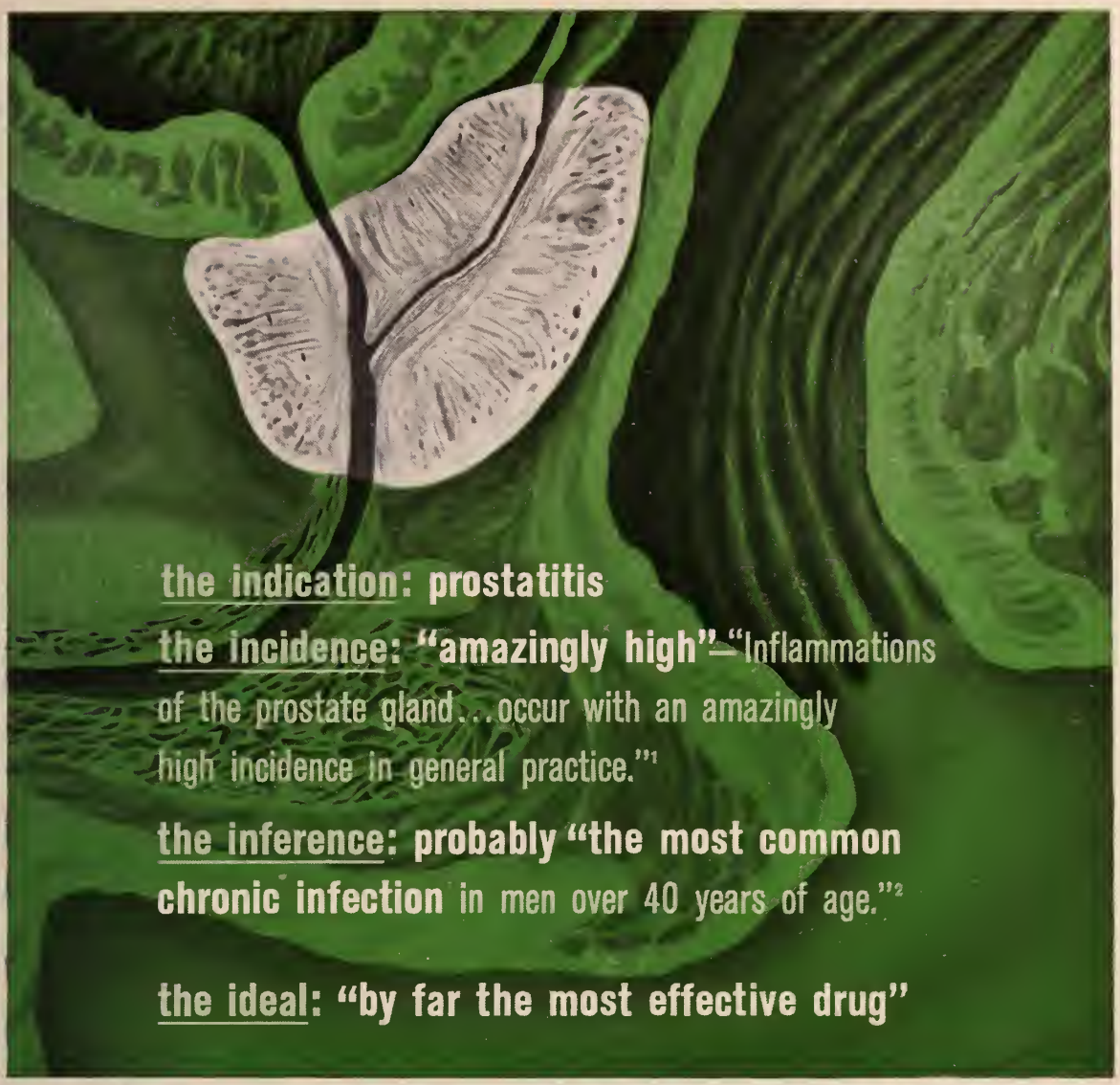
1. POWDER for weekly insufflation in your office. MICOFUR®, brand of nifuroxime. 0.5% and FUROXONE®, brand of furazolidone, 0.1% in an acidic water-dispersible base.

2. SUPPOSITORIES for continued home use each morning and night the first week and each night thereafter—especially during the important menstrual days. MICOFUR 0.375% and FUROXONE 0.25% in a water-miscible base.

Rx new box of 24 suppositories with applicator for more practical and economical therapy.

NITROFURANS—a *unique* class of antimicrobials

EATON LABORATORIES, NORWICH, NEW YORK



Furadantin®

brand of nitrofurantoin

"... by far the most effective drug to be employed, and this has been substantiated in practice. It is a drug of low toxicity and, what is more important, bacteria rarely if ever become resistant to it. It can be employed for long periods of time, is bactericidal and does not favor the appearance of monilial infections."[3]

Indicated in: acute and chronic prostatitis ▪ benign prostatic hypertrophy (to prevent or treat concomitant infection) ▪ postoperatively in prostatic surgery

Supplied: Tablets, 50 and 100 mg., Oral Suspension, 25 mg. per 5 cc. tsp.

References: 1. Campbell, M. F.: Principles of Urology, Philadelphia, W. B. Saunders Co., 1957. 2. Farman, F., and McDonald, D. F.: Brit. J. Urol. **31**:176, 1959. 3. Sanjurjo, L. A.: Med. Clin. N. America **43**:1601, 1959.

Eaton®

EATON LABORATORIES, NORWICH, NEW YORK

REPRESENTATIVE FUNERAL DIRECTORS

OF THE STATE OF NEW JERSEY

Special and Dependable Service Day and Night. Special Attention Given to Hospital Calls, Train and Express Shipments.

PLACE	NAME AND ADDRESS	TELEPHONE
ADELPHIA	C. H. T. Clayton & Son	FReehold 8-0583
ASBURY PARK	Ely Funeral Home, 514 Second Ave.	PRospect 5-0567
ASBURY PARK	Matthews, Francioni & Taylor Funeral Home, 704 7th Ave.	PRospect 5-0021
ATLANTIC CITY	H. M. Gormley Funeral Home, 911 Pacific Ave.	ATlantic City 4-3188
BERGENFIELD	Riewerts Memorial Home, 187 S. Washington Ave.	DUmont 4-0700
BLOOMFIELD	The Howard W. Kopf Funeral Home, 401 Franklin St.	PIlgrim 3-1396
BLOOMFIELD	George Van Tassel's Community Funeral Home	PIlgrim 3-1234
BOONTON	Lewis & Carey Incorporated, 312 W. Main St.	DEerfield 4-0842
CAMDEN	F. T. Walker & E. E. Walker Fun. Home, 743 Chestnut St.	WOodlawn 3-2581
CHATHAM	Wm. A. Bradley Funeral Home, 345 Main St.	MErcury 5-2428
COLLINGSWOOD	Schaffhauser Funeral Home, 983 Haddon Ave.	ULysses 4-5454
CRANBURY	A. S. Cole Son & Co., Main St.	EXport 5-0770
ELIZABETH	Aug. F. Schmidt & Son, 139 Westfield Ave.	ELIzabeth 2-2268
ENGLEWOOD	Greenleaf Funeral Home, Inc., 108 W. Palisade Ave.	ENglewood 3-0416
FREEHOLD	Van Sant Funeral Home, 73 South St.	FReehold 8-0693
HOBOKEN	Failla Memorial Home, 533 Willow Ave.	HOboken 3-0082
JERSEY CITY	Patrick J. Conte Funeral Home, 36 Tuers Ave.	HE 5-6451, DE 3-9259
JERSEY CITY	McLaughlin Funeral Home, 591 Jersey Ave.	OLdfield 3-2266
JERSEY CITY	Donald F. Wood Funeral Residence, 582 Bergen Ave.	DElaware 3-6480
LINDEN	Don McCracken Funeral Home, 2124 St. Georges Ave., E.	ELizabeth 2-3270
LITTLE FALLS	Norman A. Parker Funeral Home, 47 Main St.	CLifford 6-4700
METUCHEN	Runyon Mortuary, 568 Middlesex Ave.	LIberty 8-0149
MOORESTOWN	Harvey H. Brown Funeral Home, 10. W. Main St.	BElmont 5-5555
MORRISTOWN	Raymond A. Lanterman & Son, 126 South St.	JEfferson 9-2880
NEWARK	Barrish Funeral Home, 684 Clinton Ave.	ESsex 3-1551—9179
NEWARK	Beckett's Funeral Home, 120 W. Market St.	MItchell 2-4068
NEWARK	James E. Churchman Service, 132 Clinton Ave.	BIgelow 8-1672
NEWARK	Peoples Burial Co., 84 Broad St.	HUmboldt 2-0707
NEWFOUNDLAND	Stickle Funeral Home, Union Valley Road	OXbow 7-8141
PARAMUS	Vander Plaat Memorial Home, S-113 Fairview Ave.	DIamond 2-3688
PATERSON	Almgren Funeral Home, 336 Broadway	LAmbert 3-3800
PATERSON	R. Charles D. Legg & Sons, 384 Broadway	SHerwood 2-2385
PATERSON	Moore's Home for Funerals, 384 Totowa Ave.	ARmory 8-1500
PATERSON	Scanlan Funeral Homes, 421 Twelfth Ave. at E. 28th St.	SHerwood 2-6433
PATERSON	Vermeulen Memorial Funeral Home, 131 Haledon Ave.	MUlberry 4-3974
POINT PLEASANT	George W. Whateley Funeral Home, 1105 Arnold Ave.	TWinbrook 9-0792
RAHWAY	Lehrer Funeral Home, 275 W. Milton Ave.	FUlton 8-1874
RAMSEY	The Harold Van Emburgh Funeral Home, Inc.	DAvis 7-0030
RIDGEWOOD	C. C. Van Emburgh, Inc., 306 E. Ridgewood Ave.	GIlbert 5-0344
RIVERDALE	George E. Richards, Newark Turnpike	TEmple 5-0164
SOUTH AMBOY	The Gundrum Service, 237 Bordentown Ave.	PArkway 1-0241
SOUTH RIVER	Rezem Funeral Home, 190 Main St.	SOuth RIver 6-1191
SPOTSWOOD	Hulse Funeral Home, 455 Main St.	SOuth River 6-3041
TRENTON	Daniel Brenna Funeral Home, 340 Hamilton Ave.	EXport 3-2857
TRENTON	Ivins & Taylor, Inc., 77 Prospect St.	EXport 4-5186
TRENTON	Poulson & Van Hise, 408 Bellevue Ave.	EXPORT 6-8168
TRENTON	Saul Funeral Homes	JUniper 7-8221 and JUniper 7-0170
WEST ENGLEWOOD	Clifford H. Peinecke Funeral Home, 1312 Teaneck Rd.	TEaneck 7-2332

Squibb Announces Chemipen

Squibb Alpha-Phenoxyethyl Penicillin Potassium

new chemically improved penicillin which provides the highest blood levels that are obtainable with oral penicillin therapy

As a pioneer and leader in penicillin therapy for more than a decade, Squibb is pleased to make Chemipen, a new chemically improved oral penicillin, available for clinical use.

With Chemipen it becomes possible as well as convenient for the physician to achieve and maintain higher blood levels—with greater speed—than those produced with comparable therapeutic doses of potassium penicillin V. In fact, Chemipen is shown to have a 2:1 superiority in producing peak blood levels over potassium penicillin V.*

Extreme solubility may contribute to the higher blood levels that are so notable with Chemipen.* Equally notable is the remarkable resistance to acid decomposition (Chemipen is stable at 37°C. at pH 2 to pH 3), which in turn makes possible the convenience of oral treatment.

And the economy for your patients will be of particular interest—Chemipen costs no more than comparable penicillin V preparations.

Dosage: Doses of 125 mg. (200,000 u.) or 250 mg. (400,000 u.), t.i.d., depending on the severity of the infection. The usual precautions must be carefully observed with Chemipen, as with all penicillins. Detailed information is available on request from the Professional Service Department.

Supply: Chemipen Tablets of 125 mg. (200,000 u.) and 250 mg. (400,000 u.), bottles of 24 tablets. Chemipen Syrup (cherry-mint flavored, nonalcoholic), 125 mg. per 5 cc., 60 cc. bottles.

*Knudsen, E. T., and Rolinson, G. N.: Lancet 2:1105 (Dec. 19) 1959.

"CHEMIPEN" IS A SQUIBB TRADEMARK.

SQUIBB

Squibb Quality—the Priceless Ingredient

Specialists in Artificial Human Eyes Exclusively

TRUE TO LIFE

MADE TO ORDER IN PLASTIC OR GLASS IN OUR OWN LABORATORY AND FITTED INDIVIDUALLY

DOCTORS ARE INVITED TO VISIT

REFERRED CASES

CAREFULLY ATTENDED

and

SATISFACTION

GUARANTEED

Plastic or Glass Selections Sent on Memorandum—Eyes Also Fitted from Stock
Implants and Plastic Conformers in Stock.

FRIED & KOHLER, Inc.

665 FIFTH AVENUE
near 53rd Street

NEW YORK CITY, N. Y.
Tel. ELdorado 5-1970

"PRESCRIBE WITH CONFIDENCE"

KATES BROS.

SCIENTIFIC SHOE FITTING

A Shoe and Last for Every Foot

SOLD ON Rx ONLY
CORRECTIVE FOOTWEAR
FOR MEN-WOMEN-CHILDREN

SOLD ON Rx ONLY
OUTFLAIR SHOES
FOR CLUB FEET

177A JEFFERSON AVE.
PASSAIC, N. J.

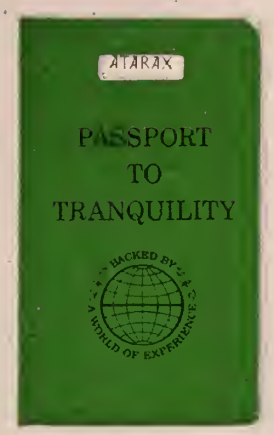
69 WESTWOOD AVE.
WESTWOOD, N. J.

202 MAIN ST.
HACKENSACK, N. J.

Dennis Brown Splints — in all sizes — carried in stock

A GUIDE TO

THE REALMS OF THERAPY BEST ATTAINED WITH



ATARAX®

(brand of hydroxyzine)

World-wide record of effectiveness—over 200 laboratory and clinical papers from 14 countries.
Widest latitude of safety and flexibility—no serious adverse clinical reaction ever documented.
Chemically distinct among tranquilizers—not a phenothiazine or a meprobamate.
Added frontiers of usefulness—antihistaminic; mildly antiarrhythmic; does not stimulate gastric secretion.

Special Advantages	Supportive Clinical Observation	...and for additional evidence
IN CHILDREN unusually safe; tasty syrup, 10 mg. tablet	"...Atarax appeared to reduce anxiety and restlessness, improve sleep patterns and make the child more amenable to the development of new patterns of behavior...." Freedman, A. M.: Pediat. Clin. North America **5**:573 (Aug.) 1958.	Bayart, J.: Acta paediat. belg. **10**:164, 1956. Ayd, F. J., Jr.: California Med. **87**:75 (Aug.) 1957. Nathan, L. A., and Andelman, M. B.: Illinois M. J. **112**:171 (Oct.) 1957.
IN ELDERLY PATIENTS well tolerated by debilitated patients	"...seems to be the agent of choice in patients suffering from removal disorientation, confusion, conversion hysteria and other psychoneurotic conditions occurring in old age." Smigel, J. O., et al.: J. Am. Geriatrics Soc. **7**:61 (Jan.) 1959.	Settel, E.: Am. Pract. & Digest Treat. **8**:1584 (Oct.) 1957. Negri, F.: Minerva med. **48**:607 (Feb. 21) 1957. Shalowitz, M.: Geriatrics **11**:312 (July) 1956.
IN ALLERGIC PATIENTS useful adjunctive therapy for asthma and dermatosis; particularly effective in urticaria	"All [asthmatic] patients reported greater calmness and were able to rest and sleep better...and led a more normal life....In chronic and acute urticaria, however, hydroxyzine was effective as the sole medicament." Santos, I. M., and Unger, L.: Presented at 14th Annual Congress, American College of Allergists, Atlantic City, New Jersey, April 23-25, 1958.	Eisenberg, B. C.: J.A.M.A. **169**:14 (Jan. 3) 1959. Coirault, R., et al.: Presse méd. **64**:2239 (Dec. 26) 1956. Robinson, H. M., Jr., et al.: South. M. J. **50**:1282 (Oct.) 1957.
IN HYPEREMOTIVE ADULTS does not impair mental acuity	"...especially well-suited for ambulatory neurotics who must work, drive a car, or operate machinery." Ayd, F. J., Jr.: New York J. Med. **57**:1742 (May 15) 1957.	Garber, R. C., Jr.: J. Florida M. A. **45**:549 (Nov.) 1958. Menger, H. C.: New York J. Med. **58**:1684 (May 15) 1958. Farah, L.: Internat. Rec. Med. **169**:379 (June) 1956.

New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being

SUPPLIED: Tablets, 10 mg., 25 mg., 100 mg.; bottles of 100. Syrup (10 mg. per tsp.), pint bottles. Parenteral Solution: 25 mg./cc. in 10 cc. multiple-dose vials; 50 mg./cc. in 2 cc. ampules.

Co-Pyronil®

keeps most allergic patients symptom-free around the clock

Many allergic patients require only *one* Pulvule® Co-Pyronil every *twelve** hours, because Co-Pyronil provides:

- Prolonged antihistaminic action
- Fast antihistaminic action

  plus
- Safe, effective sympathomimetic therapy

*Unusually severe allergic conditions may require more frequent administration. Co-Pyronil rarely causes sedation and, even in high dosage, has a very low incidence of side-effects.

Supplied as Pulvules, Suspension, and Pediatric Pulvules.

Co-Pyronil® (pyrrobutamine compound, Lilly)

Lilly
QUALITY / RESEARCH / INTEGRITY

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U.S.A.

058012

THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

Opiferque

On the seal of The Medical Society of New Jersey appear four Latin words, *Opiferque per orbem dicor.* A century ago, physicians were well enough educated to be able to read this motto at sight. Not only that, but they knew it was a quotation from Ovid and that it meant: "Throughout the world, I am called the Help Bringer": *Op*—good things, such as health (as in opulent); *fer*—to carry or bring (as in ferry); *que*—and. It was Apollo's description of himself—Apollo, the pre-Aesculapian god of medicine: *inventum medicinae meum est, opiferque per orbem dicor, et herbarum subjecta potentia nobis.* To most of us today that's as much Greek as Latin, but to our spiritual ancestors it was simple: "The art of medicine is my discovery, and I am called Help-bringer throughout the world; and the power of all herbs is known to me."

These reflections are prompted by the appearance of a book called "Help Bringers: Versatile Physicians of New Jersey." Written by Fred B. Rogers, M.D., archivist of our Society and chairman of our Publication Committee. The book was released by The Vantage Press on July 23—the birthday of The Medical Society of New Jersey. It consists of biographies of twelve New Jersey physicians, running the time spectrum from colonial days to the twentieth century. Many of these doctors also made contributions to other aspects of the cultural life of our country. Dr. Thomas Dunn English composed "Ben Bolt." Dr. Ezra Mundy Hunt was one of the founders of the American Public Health Association. Dr. Abraham Coles was the well known hymnist. Dr. William A. Newell was the only physician to be Governor of our state. The galaxy runs from John Browne, Benjamin Franklin's friend and confidant, to Dr Henry L. Coit

PUBLISHED MONTHLY SINCE 1904
Under the direction of the Committee on Publication
FRED B. ROGERS, M.D., *Chairman*

HENRY A. DAVIDSON, M.D., *Editor*
MIRIAM N. ARMSTRONG, *Assistant Editor*

Place of Publication, Printing and Mailing—116 Lincoln Avenue, Orange, N. J.
Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.
Send all communications for publication to P.O. Box 904, Trenton 5, N. J. — Telephone EXport 4-3154
Each paying member of the State Society is entitled to receive a copy of THE JOURNAL every month
Whole Number of Issues 672

VOL. 57, No. 8 AUGUST, 1960 Subscriptions, $3.00 per Year
Single Copies, 30 Cents

(whom some of our senior colleagues remember personally) the pioneer pediatrician who devised Certified Milk and who, more than any other person, promoted Milk Commissions for child welfare.

Dr. Rogers' book is a document we can all be proud of. It records the stories of the gifted and dedicated men who gave us a heritage that compares favorably with the spiritual legacy of any group of doctors in the world.

The Fall and Rise of Uroscopy

Ancient pictures show the venerably gowned physician gazing solemnly at a glass of urine. He holds the specimen up to the light and looks wisely at it. This process, called uroscopy, was one of the medical mysteries taught only to initiates. Without microscope or chemical tests, the medieval doctor looked through the urine and detected more things wrong than a chiropractor can see in one of his "spinographs."

With the advance of medical knowledge, it became apparent that there was a lot of hocus pocus in uroscopy. So the art became discredited. When simple tests were developed for acidity, sugar and albumen, the process was redesignated "urine analysis" (syncopated into urinalysis) and became the *pons asinorum* for medical students and medical technologists.

Those of us who have not been close to biochemistry or internal medicine may not realize the extent to which urine analysis has become a major diagnostic tool. In addition to the original quarries—acidity, sugar, albumen, casts, blood and pus, the modern technologist now hunts for cystine, tyrosine, pophyrins, creatinine, bile and hormones. He looks for indican, spermatozoa, fat, uric acid, phosphates, and acetone bodies. He no longer leans on simple inspection, or even on microscopy. Instead he depends on turbidimetry, dialysis, colorimetry and spectrum analysis. The urine gives information about absorption of antibiotics, fluid balance, sugar metabolism, kidney function, and pregnancy.

Urine, after all, is not simply a bodily reject. It is an inherent part of the human fluid cycle, a portable culture medium for bacteria, and, when properly interpreted, a veritable signal corps of disease. Urine analysis, once scorned as the primer for interns, has again become a serious and major branch of human diagnostics.

Medical Prepayment and Philosophy

"A curious paradox of some contemporary philosophy is the idea that man should spend for his pleasures rather than for his needs. It is appropriate, so this reasoning goes, that he should buy a television set, a vacation in Florida or an outboard motor boat. These are cardinal rights. But for something that he really needs, such as his life or his health, or the life of his child, someone else should pay. This may be the Government, his employer, his union, his great-aunt or anyone else who can be cajoled or coerced into paying the price for him. If no one else will pay for it, the doctor should serve him for nothing."

This observation by Dr. C. Marshall Lee,* raises a question of crucial importance to the whole pattern of our American society.

For, as Dr. Lee puts it, the attitude he de-

scribes "may be acceptable for the child of an indulgent parent, but it is not appropriate for a free man in a free society."

What can the doctor do to counteract this philosophy and to forestall the socialization of medicine which may be its ultimate product? For one thing, the doctor should learn all he can learn about our voluntary medical prepayment programs. Physicians should recognize that, in Dr. Lee's words, "Far from being the meddlesome 'third party' for which they have an uneasy fear, (the prepayment program) stands with them in the common effort to preserve a cherished concept of freedom."

Second, the doctor—and only he—can make these programs operate to the satisfaction of the patient. Only he can see to it that the subscriber gets full value for the premium dollar he has invested in our voluntary medical care program.

Finally, our own sponsored Blue Shield Plans offer the American doctor an opportunity to strengthen and confirm his patient's confidence in our traditional way of practicing medicine; and an opportunity to participate actively in guiding the destiny of our medical prepayment program in the days ahead.

**"The Challenge of Medical-Care Insurance," C. Marshall Lee, Jr., M.D., The New England Journal of Medicine, 262:332 (Feb. 18, 1960).

George N. J. Sommer (1874-1960)

In our Blue Book there appears a short list of Fellows. These are the men who year by year are chosen by their colleagues to lead the oldest medical society in America. The title Fellow conveys a unique honor, for the company is a small one. Only yesterday there were 19 of them. Now there are 18. For on the first day of summer 1960, we lost our Senior Fellow: George N. J. Sommer.

He was born in Trenton in 1874—when Ulysses S. Grant was President of the United States. At the age of 20, the University of Pennsylvania awarded him an M.D. degree. He then did graduate work at the University of Berlin. (That was in the days when foreign medical graduates were honored!) In 1896 he returned to his native city and became affiliated with St. Francis Hospital. It was the beginning of a 50-year relationship which would catapult Dr. Sommer to the medical directorship of the hospital.

Dr. Sommer belonged to the old school of medicine—the school which taught that the physician had civic duties as well as purely clinical ones. He was active in the famous Trenton Symposium, in the Trenton Historical Society, in the local Chamber of Commerce and in the Tadpole Club of our capital city. He was a charter member—indeed the last surviving charter member of the Trenton Council, Knights of Columbus.

Dr. Sommer was a urologist—one of the pioneer urologists of the east. He was also president of the New Jersey Society of Surgeons and served the Mercer County Medical Society in all its posts, becoming president of that component society in 1900. And 30 years later he became the 137th President of The Medical Society of New Jersey.

He was so long identified with medical, civic and cultural activities in our state, that we think his two middle initials must have stood for New Jersey. It would have been a worthy choice for in his personal qualities he could well have been a proud eponym for New Jersey.

George N. J. Sommer presented a public image of the physician that was never tarnished. We need more like him.

Original Articles • • •

JESSE MCCALL, M.D.

Newton

The Science and Art of Medicine*

I HAVE long known that pride and humility are not incompatible. Of late the circumstances of my life have led me to discover that frequently they are complementary to each other—that they go hand in hand. Together they possess my heart today . . . pride that so much of good and of honor have come to me; humility because I clearly see how little I have myself deserved and how much is due to the love and generosity of others. So—in the words of the song—"For all the joy that now is mine, thanks be to God," and thanks to all of those who by the gifts of their giving have enriched my life, and have placed me forever in their debt.

This is a moment of wonder for me. I recall with what uneasy hope as a boy I embraced the dream of becoming a doctor. How long and how beset with obstacles was the uphill road! How frequently my flagging hopes threatened to give way to despair! Yet here I stand before you now, trying to put into words the feelings that are mine as I enter upon my duties as the 168th President of The Medical Society of New Jersey. With thrilling appropriateness Browning's lines suggest themselves:

> For the journey is done and the summit attained
> And the barriers fall,
> Though a battle's to fight ere the guerdon be gained,
> The reward of it all.

Surely this is a summit attained; and barriers have fallen—almost unnumbered barriers—to give me access to this present eminence. And I'm sure there's a battle to fight before—at the close of my presidential year—I win the guerdon of a sincere "well done" from those who watch and evaluate my efforts.

To that battle I pledge myself in behalf of the true good of Medicine and of the people. To it I promise I shall give my unwavering best—so help me God!

There is a certain spirit of knight-errantry about all those who enter the lists of life flying the pennons of Medicine. In early youth, they find a cause worthy of their devotion. To its service they give themselves—with all the thews and vigors of their minds and souls. Moved by love, it is their task to prove themselves in battle—and their powerful adversaries are disease and death.

Across the centuries and in innumerable engagements they have proved themselves, and still they do—with increasing impressiveness—every passing day. In consequence, men and women everywhere have reasons to bless their exploits in gratefulness for high boons received of better, longer, and more vigorous life.

There is no place in Medicine for those not on battle bent. There is no place for sluggards or cravens. Physicians serve life, and life is itself a struggle—a struggle for survival that begins for each of us in the process by which we are conceived, and that continues, through varying phases, until the dramatic hour when finally we succumb, as succumb we all must,

*Inaugural Address, presented at the General Session, 194th Annual Meeting, May 16, 1960.

not because of the failure of Medicine to protect us but because of the inexorability of the law within our natures which dooms us all to die.

To one who realizes that struggle is essentially inseparable from life, that the state of health represents the body's triumph over the constant threats and aggressions of disease, it is disconcerting almost to the point of violence to be confronted with the unrealistic and disarming philosophy that "easy does it" . . . that without the expenditure of effort, without work, we can still develop and enjoy the good things of life and of living. Nothing is further from the truth.

On the contrary, the whole history of mankind demonstrates that every achievement in art or science, every improvement in the lot of man, every advance in civilization and cultural refinement has been in direct proportion to the constructive hard work of people consistently striving to make the most of their best. The only thing that man can do easily is to fail. To convince him otherwise is to subvert his reason, to act in enmity against him, and to bring him ultimately to misery and to ruin.

THE man or woman who effectively and efficiently practices Medicine knows that at any moment it is necessary to be ready to fight to the very death. That is why we spend so much time and effort making ourselves able to serve as champions of those who have not the means or the power of fighting for themselves. That is why we give so much time and effort to mastering the necessary science of medicine before we essay the exercise of its art. For—make no mistake—the study of Medicine is a science, but the practice of Medicine is an art.

In view of flourishing popular confusion of notions in this regard, I wish to enlarge upon this basic truth. It is fundamental if we are to understand why in medical practice we cannot guarantee uniformity of results. It is basic if we are to recognize that the physician or surgeon who succeeds with one patient may fail with the next. Each case is a new and challenging single combat, whose outcome will be individually determined, and will be the measure of the triumph or failure of the practitioner's art.

The science of Medicine is the systematized knowledge—constantly increasing—of all those things which one must know to enable him as a physician to fight effectively for his patient's life and well-being. It embraces everything from a knowledge of anatomy and physiology to a knowledge of the most recently discovered modalities and technics. Mastery of the science of Medicine is prerequisite for the exercise of the art of Medicine. But that art is something more.

Simply defined—art is the proper way of doing anything. In Medicine it is the ability to select and make use of the particular knowledge and skills necessary to save this particular patient in these particular circumstances. I emphasize that mastery of the necessary science prepares one for, but does not guarantee the command of, the necessary art.

Science knows, but art does. For example, the teacher of singing knows all about singing—as a science—but unless he has a voice and musicianship he still will not be able to exercise the art of singing. The great singer, therefore, not only knows the theory of voice production and tonal placement—the science of singing—but he is able to use that knowledge for the triumphal evocation of his song. And even he—when circumstances develop which he cannot control—such as fatigue or disease—may at any time fail in the rendition of an aria or song which previously he has repeatedly sung with consummate artistry.

The circumstances attending the exercise of the art of the practice of Medicine are still more complicated. The singer regularly uses, of course, only his own voice. He plays, as it were, always on the same familiar and disciplined instrument—as for the most part do all other instrumental artists. But not so the physician or surgeon. Each new patient is an utterly new complex, reacting frequently in utterly individual and idiosyncratic fashion. Thus the physician or surgeon—though his own skills and competences are constant—is

dependent for success upon the way in which this new instrument which is his patient responds, and upon the way in which he can control and make the most of those responses.

Nor is even the ability to deal with the varying physical conditions and reactions of patients enough. The practicing physician or surgeon must establish a psychological rapport with his patient, or all his knowledge and skill may be undermined, and the results of his efforts will be disappointing.

For the man or woman of Medicine there is always a battle to fight ere the guerdon be gained, a battle as subtly complicated and as elusively difficult as any challenging the vision and valor of men. It is the glory of Medicine that despite all these factors of hazard and uncertainty, so regularly and so splendidly such battles are being won.

OF LATE there has been growing clamor for the faceless regimentation of medical practice. It can only proceed from ignorance of the very nature of medical practice as an art. Art is inevitably personal. It is instinct with style, and style is the characteristic manifestation of the personality of the artist. That is why we can recognize a man from his writing or his painting or his artistic work in any medium. That is why we like the works of some artists, and either fail to appreciate or actively dislike the works of others. That is why as intelligent persons we must and do choose our physicians and surgeons. That is why Medicine impersonally practiced will never succeed or satisfy. That is why when better medicine is practiced, dedicated, free, individual physicians will practice it. That is why assembly-line, regimented, impersonal medical practice will not and cannot succeed.

It is one of our tasks to make people understand this. The best way in which we can insure their understanding is for each of us, in the best traditions of Medicine, so ably and artistically to tend and serve our patients that they will be moved to admiration and gratitude for both the art and the artist.

It is my hope that, during the year of my presidency, we who are the physicians and surgeons of New Jersey will achieve a rededication to our art that will generate a deepening of the bonds of admiration and affection which really make those whom we take care of "our" patients. It shall be my purpose to stimulate this response. With this accomplished —with the doctor-patient relationship happily maintained as it should be—we can then, with the sympathy and cooperation of our people, address ourselves to the solution of the fretful but less important economic considerations that confront us all.

I remind you that the true knight was always in his element in battle. So must we be, if we are to be worthy of our lineage. But like the true knight let us charge into action buoyed by the invigorating knowledge that love and good wishes attend us. Thus chivalrously fortified, well-trained and properly dedicated, we cannot but prevail.

49 High Street

Moving Picture Summaries Available

Reviews of medical motion pictures are now available on request from the Film Library of the A.M.A. This publication is prepared by the Department of Medical Motion Pictures and Television and contains reprints of all reviews published in *The Journal* of the A.M.A. during 1959. For your copy, write to A.M.A. at 535 North Dearborn Street, Chicago.

Ulysses M. Frank, M.D.

Millburn

Problems of Aging*

The sadness of old age is due not to the end of joy but to the end of hope. It need not always be that way, as Dr. Frank here points out in this compact treatment of the biologic, social and clinical aspects of growing old.

The explosive growth of our over-65 year old population, presents a serious problem to our nation. This situation, too greatly ignored, is one of the most urgent and heart-rending of our time. This problem has never been so vast nor solutions so inadequate as now.

Since 1900, with better medical care, average life expectancy has increased by 20 years. Today, there are five times as many aged as in 1900. The problem of old age comes almost over night. When a man retires or when a woman's husband dies, the income of 60 per cent of the aged falls to $1,000 a year or less. Most remain in their life-long homes, scrimping to the bone. They fear the loss of precious independence, or the loneliness of a furnished room, or the illness that can leave them in a nursing home or even a state hospital.

A crisis for the individual, old age is also a national problem involving huge outlays of money. It will grow as an economic factor with more demands for aid to a group forced to be unproductive. Life expectancy today, is 70 years for men and 73 for women. Fifteen million people are 65 years or over. In 1970 there will be 20,000,000 in that category: 11 per cent of the population. Retirement and care for the aged is becoming one of the major problems of our time.

In the wide field of help for the aged, Congress will pass some legislation increasing the social security benefits. The Senate Subcommittee on Aging, has been holding hearings and will recommend priority to the financing of medical and hospital care for the aged. Congress is keenly aware of the need for research in this area. The role the Veterans Administration will play in this field, has prompted Dr. Middleton to create a "Research in Aging" division.

At a meeting with the VA advisory committee on the problems of aging, a "crash program" was proposed. This would embrace problems at four levels: (1) the molecular level, (2) the cellular level, manifested through connective tissue, (3) the organ level, (4) the group or functional level.

THE BIOLOGY OF AGING

Time does not allow me to go into the biochemistry of the process of aging, with concepts of the chemical constitution of the ground substance and the importance of the mucopolysaccarides or the new concept of aging by capillary fibrosis introduced by Dr. Handler of Duke University.

Heredity plays a role in the process of aging, and gives clues to the resistance to disease. Resistance may be the secret to longevity. It determines the life span of certain individuals. Resistance to disease may be acquired or inherited. The acquired type comes as a result of exposure, either naturally or by vaccination to a specific disease-producing or-

*Presented March 2, 1960 before the medical staff of the Newark Regional Office, Veterans Administration.

ganism. The inherited type is an inborn resistance which gives the individual a high degree of resistance against infectious and non-infectious diseases. It appears to be part of the individual's constitutional make-up transmitted by heredity. This general inborn resistance seems to protect the individual against both infectious and degenerative diseases. It also determines the length of his life span by slowing down the rate of the aging process.

Long term studies by Simms,[1] reported that 90 per cent of deaths in the United States each year result principally from the progressive loss of resistance to disease with advancing age. These studies have provided the first real clue to the puzzle of why some individuals grow older at a faster rate than others. They suggest that we are all born with a built-in, "biologic clock" and that the rate of ticking of this clock is governed by an individual's hereditary resistance, which serves as a brake to keep the clock from ticking at too fast a pace. The slower the rate loss of this inborn resistance, the longer the life span of the individual.

Oliver Wendell Holmes once remarked: "To live long, one must advertise for a couple of parents both belonging to long-lived families some years before birth."

Progress has been made in our understanding of the role of certain tissues in the stimulation and regulation of this natural resistance. So, instead of having long life parents, it may be possible to have chemical counterparts to long-lived ancestors by having an artificial producing resistance system of our own making.

Recent fundamental studies on the nature of natural resistance have provided strong evidence that this resistance originated and is controlled by the group of connective tissues, part of the body's "soft skeleton" known as the reticulo-endothelial system or RES. This is a vast network or reticulum of cells that constitutes the lining or endothelium of many organs, such as the liver, spleen, bone marrow and lungs.

The knowledge of the protective role of the reticulo-endothelial system, has opened up a new line of research that could lead to one of the most revolutionary developments in medicine.

The aim is to provide artificial stimulation to the activity of the reticulo-endothelial cells by chemical and immunologic methods. Instead of combating diseases individually, the chemical stimulaton of the body's own natural resistance system would thus provide a biologic defense against disease in general. Infectious as well as non-infectious, including the degenerative diseases that strike the greatly increasing older age groups, such as arteriosclerosis, heart disease, hypertension and cancer. Such an approach would be a check against the aging process itself, keeping the individual at a younger level by reducing the rate at which his general resistance would otherwise decline.

Heller[2] reported using a fatty substance derived from the shell of bacteria to stimulate the reticulo-endothelial system activity of rats, mice, guinea pigs and pheasants, so they could withstand as many as thirty lethal doses of botulinus toxins, the most powerful poisonous substance known. Eight ounces of this are enough to wipe out the world's entire population. Maybe this is the secret weapon of the new germ warfare.

Byers[3] reported a connection between the reticulo-endothelial system and the level of fats such as cholesterol in the blood stream. Byers found that the reticulo-endothelial system acts to remove cholesterol and other fats from the blood.

Old[4] and his associates reported that bacterial and other agents that stimulate the activity of the reticulo-endothelial system and decrease the susceptibility to bacterial challenge have been found to protect mice, partly or completely against the challenge with a type of cancer named Sarcoma 180. In addition, survival time increased two-fold in such animals when they were inoculated with another type of cancer named *Ehrlich Acites*.

Tumor retardation and prolonged survival

1. Professor Henry R. Simms, College of Physicians and Surgeons, Columbia University.

2. Dr. John Heller of the New England Institute of Medical Research.

3. Dr. Sanford O. Byers of Mount Zion Hospital, San Francisco.

4. Dr. Lloyd J. Old of the Sloan Kettering Institute for Cancer Research and The University College of Medicine.

time was observed in animals when a third type of tumor (Carcinoma 755) was transplanted after their reticulo-endothelial system was stimulated by bacterial agents.

Cancer has been observed to regress spontaneously during, or following an acute bacterial infection. Some of you remember your early medical books on Coley's Serum. Coley[5] used mixed bacterial toxins in his effort to combat cancer 50 years ago.

Old's efforts[4] to produce cancer recession by stimulating the reticulo-endothelial system is not far from Coley's approach which may yet be revived with improved technics.

Reticulo-endothelial cells may be divided into two groups: fixed and the wandering. One of their chief functions is phagocytosis: an important and powerful means by which the defense of the body is sustained.

Metchnikoff knew about this years ago. Influenced by his theory, two Soviet scientists, both named Bogomoletz, and their followers, reported that small doses of a serum containing anti-bodies (produced by injection into animals of reticulo-endothelial cells) had a mitigating effect on degenerative changes due to age.

CLINICAL ASPECTS

Is aging a normal process of involutionary changes or a pathologic deviation? This is a problem in research. Degenerative disease processes may be difficult to differentiate from "ordinary" effects of aging.

A critical period develops during this stage when symptoms are sometimes mistaken for old age "complaints." These ailments may be ignored by old patients because they do not seriously interfere with daily functioning and treatment may be delayed. A tabulation of chronic disorders in people over the age of 65 was made by investigators. Diseases of the heart and circulation head the list.

Three separate forms of aging enter into the decline of vital functions. The first are called *secular changes*. Resistance to secular changes with no untoward developments to impair health is "ideal aging;" when this applies, a person should not die until he is 125 years old, according to Anton J. Carlson. There is a balance between specialization by the tissue and the available metabolic support. Any process that will upset this balance will hasten aging. A second type of aging is the result of *accelerating factors*. The organs thus affected show changes similar to those of secular aging but they are more pronounced and occur at an earlier age. Examples are found in the vascular system of patients with hypertension, in weight bearing points, subjected to excess strain of heavy labor, or in the lungs affected by emphysema. A third form is the *pathologic complication* of aging. In this category are the majority of geriatric diseases. Two typical forms are atherosclerosis and cancer.

Some prominent persons have successfully resisted these secular changes. Among them are Anna (Grandma) Moses—age 98; Harry Emerson Fosdick—age 80; Sir Winston Churchill—age 84; Chancellor Adenauer—age 86; Bernard Baruch—age 87; Senator Francis Green—age 90; and others.

Three forms of tissue have their involutions at different age levels: (1) temporary organs, (2) autumnal organs, (3) permanent organs.

William Lawrence, Science Editor of the New York *Times*, accompanied a crew on a nuclear bombing mission, as an observer, over Hiroshima. He predicts that, with the use of atomic medicine, persons could reach the age of 100 in the near future and feel as energetic as a man of 50 instead of being disabled by the feebleness that accompanies degenerative diseases during that age period.

So, we have added years to life and now comes the problem of adding life to years. Our present answer to this challenge is in the development of geriatrics as a specialty.

A survey of cerebrovascular disorders made in 1950 showed that half of the older patients suffered from vertigo. A more recent Finnish study revealed a clear connection between dizziness and cerebral arteriosclerosis. *Hypertension*, it was found, was not the primary cause of dizziness. Alvarez has emphasized the role of "little strokes" or minor cere-

5. Dr. William B. Coley: American Medical Journal, 1906, and Boston Medical and Surgical Journal, Jan. 1915.

bral accidents, such as "acute indigestion," epigastric pain, abdominal distention, rapid loss of weight, difficulty in swallowing and vertigo. The common clue in each case was a sudden change in the patient's personality, shown by confusion, depression, irritability and lack of concentration. Sudden disturbances of the cerebral function in elderly people, do *not* necessarily originate in the cerebral vessels. The culprit may be a thrombus in the internal carotid artery.

The diagnosis of myocardial infarct, which is relatively simple in younger people is sneakingly deceptive in the aged. In one recent study, mortality from myocardial infarction was 45 per cent in a group over the age of 70, compared with 17 per cent of those under the age of 60. Common pitfalls in this diagnosis were a sudden exacerbation of dyspnea, which may mask a silent myocardial infarct. Vertigo or mental confusion may be attributed to cerebral arteriosclerosis without suspecting coronary disease. The traditional insistence on bed rest for the aged cardiac needs rethinking, according to Levine.[6] He advocates a chair instead of a bed. Bed rest, he suggests, weakens a debilitated circulation.

Antibiotics have conspicuously reduced deaths from bronchial and pulmonary disease. Though chronic bronchitis is still a major geriatric problem, its death rate has been sharply reduced by prophylactic use of small daily doses of the more versatile antibiotics during acute stages. Less easy to control is the rising incidence of chronic pulmonary tuberculosis in the elderly. Diagnosis is usually difficult. Frequently, the only symptoms are debility and loss of weight, which are attributed to old age. This becomes a public health problem because "grandpa" became a focus of infection for the family.

SOCIOLOGIC ASPECTS

When should an individual become non-productive? Is mandatory retirement at a predetermined age a good thing? There is a vast difference between forced and voluntary retirement. The worker who is compelled to retire resents it. It may be that industry and the family are laying waste older persons by discarding them prematurely. Does compulsory retirement actually kill? If you retire of your own volition, you are not static; your mental processes are at work and still capable of productive work.

Eddie Cantor in his book, *The Way I See It*, says that we should begin preparing for age 60 when we are 16. He suggests we begin developing long-range interests and hobbies at least by the age of 46. Mr. Cantor adds that "mental rigidity is responsible for most of the misery of old age." In another passage, he says: "while boredom isn't officially listed as a degenerative disease and the cause of death, it's a well established fact you won't live very long without any interests in life."

Some psychiatrists complain that many aged patients were being admitted to mental hospitals only for the convenience of their families. And a former president of the American Medical Association said that employees were being retired who were still productive. These capable people were being thrown into a morass of misery.

Bartemeier[7] finds that 35 per cent of all patients in psychiatric hospitals were over the age of 65. Most of them, he thinks, should be cared for by their families. He stated that work slows premature aging and that depriving older persons of work was keeping them from discharging basically destructive energy. Orr[8] is openly critical of employers who force retirement at 65. He says: "A combination of ignorance, bigotry and prejudice, has helped to keep many of our 15,000,000 senior citizens in a state of loneliness and frustration. The retired person must be given responsibilities, must feel that he is truly wanted, must retain his sense of dignity and importance as a human being."

We are the only country among the civilized nations that emphasize youth as an important factor in our cultural life. Our motion pictures, television, radio and magazine advertisements are all directed to that end. Mothers dress like daughters and grandmothers like

6. Samuel Levine, M.D., of Harvard University, where he is Associate Professor of Medicine.

7. Dr. Bartemeier is Medical Director of the Seton Institute of Baltimore.

8. Dr. Louis Orr is President of the American Medical Association.

grandchildren. It is often difficult to tell the age of our elderly women. Even some of our older men hide their age by dyeing their hair or wearing toupees. There is a dreadful fear of looking old. They do not want to be discarded and lonely. They want to avoid hostility and derision by the younger generation. They fear the loss of dignity and reverence which is so prevalent in these United States. Chinese and Japanese senior citizens, however, are honored and dignified by their juniors. Senility with its mental problems and juvenile delinquency do not exist in such communities.

The economic problem here is a crucial one, especially for those who have to subsist on social-security payments. Many need part-time jobs to supplement meager retirement incomes. President Eisenhower has called inflation the number one threat to retired people on fixed incomes. The rising cost of living is an insatiable termite boring away at their means of subsistence. The care of our aged population might become one of the important political issues in the presidential campaign.

Helping the older person retire gracefully has become a new business and a big one. Some corporations put employees reaching retirement age on a part-time basis, so that they can reduce the shock of abrupt retirement by going through gradual adjustment to the idea.

Standard Oil of New Jersey, Eastman Kodak and several other large companies now have pre-retirement counseling programs. Some years before retirement, its problems are discussed in group meetings. Various agencies are available for practical advice on such subjects as health, pensions, investments and so on. The successful retiree has been described as one who can entertain himself, entertain another person and entertain a new idea. This is the type of a senior citizen the modern corporation, through its retirement counseling service, wants to develop. Here is a proposed guide-line for happy retirement.

(1) Safeguard your future health by periodic medical examinations.
(2) Take long vacations from your job periodically (if possible) so as not to become "job-centered."
(3) Develop real interests or hobbies.
(4) Decide where you want to live in retirement.
(5) Make new friends continually—some younger, some older than yourself.
(6) Set a financial goal for retirement; then figure out how to meet it.
(7) Never make retirement the end of all physical, mental and intellectual activity.
(8) Take a good look at yourself and ask this question, "What kind of person am I becoming?"

Somerset Maugham once wrote—"For the complete life, the perfect pattern includes old age as well as youth and maturity; the beauty of the morning and the radiance of noon are good but it would be a silly person who drew the curtains and turned on the light in order to shut out the tranquility of the evening."

12 Undercliff Road

Drug Addicts Are Younger

Drug addiction may no longer be as widespread as it once was, but its victims today are much younger than before. The October 1959 issue of *Patterns of Disease*, published by Parke, Davis & Company for the medical profession, traces the decline of drug addiction—from an all-time high of 195,000 in 1915, to 70,000 twenty years ago, to its present low level of 46,000. But where the addict of twenty years ago was bordering on middle age, he is today "probably a male in his middle 20's who has been addicted to heroin since he was about 20." Compared to this, "this typical patient at U. S. Public Health Service Hospitals twenty years ago was a male, 38 years old, who had become addicted to morphine at 27," *Patterns* states.

M. J. Rowen, M.D.

Elizabeth

Psychoneuroses in Medical Practice

It is generally said that about half of the general practitioner's case load consists of neurotic patients. Dr. Rowen reports a study of his own practice which suggests that 17 per cent is a more accurate figure.

The preponderance of medical attention for adults is given by general practitioners and internists in their offices. The ambulatory and "mildly sick" individual occupies most of the practicing physician's time and energy. Medical articles and textbooks say that many of the ambulatory office patients belong to a poorly defined group classified as "psychoneurotics." Thus, Harrison[1] in his widely read textbook states that the "average physician" will find that between 50 and 75 per cent of his patients are suffering from pure psychoneuroses or from superimposition of a neurotic reaction upon organic disease. Terhune[2] reports that nearly half his practice is devoted to "functional disorders," while most of what remained represented a combination of organic and functional disturbances. Observers such as Aldrich[3] and Redlich[4] agree that disorders of this type make up a significant share of the general physician's practice. The non-psychiatrist is most usually faced with this problem in its everyday evolution.

The present report is concerned with 1054 consecutive office visits made by ambulatory patients for all varieties of general medical complaints. A statistical study was instigated to ascertain what proportion of these patients were suffering from primary "neurotic" rather than organic disease.

PROCEDURE

The appraisal of the patients was done by myself (a practicing internist). It is subject to the ordinary errors of omission, mistaken diagnosis, and misinterpretation. My practice is a cross-section of an adult working, middle class population from an urban community of 120,000 people, with a mixture of many ethnic groups. Nearly all of these patients can converse in English. The patients were all ambulatory. None were from the hospitalized group. Very few doctors referred consultations in the office, since most consultation cases were seen in the hospital.

Many patients exhibited more than one disease; but an attempt was made to classify the single most important complaint or disease present. Numerous patients exhibited combinations of disease. They had to be put in a group arbitrarily based on the examiner's judgment. In this, there must be some margin of error. It was noted early in the study, that some people overdramatize symptoms and showed neurotic reactions to organic pathol-

1. Harrison, T. A.: *Principles of Internal Medicine;* ed. 2, 1954, McGraw-Hill. New York, N. Y., p. 227.
2. Terhune, W. B.: Med. Ann. District of Columbia, 28:305 (1959).
3. Aldrich, C. K.: Journal of Chronic Diseases, 9:212 (1959).
4. Redlich, F. C.: *Factor* (Professional News Bureau, New York), 1:14 (1959).

ogy. Still, if the organic disease was the basis of the complaints, these patients would not have presented themselves to the physician without organic disease. This study was an attempt to see how many patients were coming to the office with complaints that were predominantly or wholly of a "neurotic" nature. In the series, I included all the patients who came to the office consecutively. Some were included more than once because they came repeatedly, either for the same or for new complaints. The disease groups were classified into cardiovascular, pulmonary, infectious, hemic, renal, musculoskeletal, gastrointestinal, psychoneurotic, psychotic, endocrine, dermatologic, allergic, insurance examinations and miscellaneous (Figure 1).

FIGURE 1.

COMPARATIVE NUMBERS AND PERCENTAGES OF PATIENTS SEEN AND CLASSIFIED FOR THEIR PREDOMINANT COMPLAINTS OR DISEASES

Disease Group	Number of Cases	Per Cent of Total
Cardiovascular	195	18.5
Pulmonary	46	4.3
Infectious	101	9.6
Hemic	38	3.6
Renal	10	0.9
Musculoskeletal	141	13.4
Gastrointestinal	44	4.1
Psychotic	22	2.1
Psychoneurotic	178	16.9
Endocrine	114	10.8
Dermatologic	23	2.1
Allergic	73	6.9
Examinations*	69	6.5
Total	1,054	100.0

*For insurance or employment purposes.

The classification followed the standard definitions whenever possible. The *cardiovascular* group included organic cardiac disease, peripheral vascular disease, hypertension, arteriosclerosis, and related disorders. The *pulmonary* classification consisted of such commonly noted conditions as bronchitis, pulmonary fibrosis, emphysema, asthma, tuberculosis, pneumonia, and the like.

The *musculoskeletal* group included the arthritides, arthralgias, muscular strains and sprains, accidental injuries and post-traumatic musculoskeletal symptoms. Classified as *psychotic* were patients who had, or had had, psychoses, where that diagnosis had been verified by a psychiatrist. The *endocrine* group formed a large segment (almost 11 per cent) of the practice. Here I included such conditions as diabetes, obesity and hypometabolism. Under the latter heading was the obese female who is trying to lose weight, who does not have symptoms of typical hypothyroidism but who is coming to the doctor for weight reduction and other minor complaints.

The *"neurotic"* group was diagnosed and classified according to standard definitions noting that the patient who is suffering from this disease retains an awareness of external reality and (except for specific neurotic disorder) personality organization is also maintained. More psychiatrically oriented physicians may use terms like "psychoneurosis," "inappropriate displacement fixation," "transference neurosis," "anxiety neurosis," "anxiety hysteria," "neurasthenia," and many others, but the connotation is the same. Nevertheless, the physician is not justified in considering symptoms as psychoneurotic unless psychogenic factors can explain the syndrome. A diagnosis of psychoneurosis was not made because of the absence of "organic or physical disease" or by exclusion of all known organic factors. The definition in Stedman's dictionary[5] is: "A disease of the nerves or nervous system especially without lesion of parts; a functional nervous disease or one which is dependent upon no evident lesion; a peculiar state of tension or irritability of the nervous system; any form of nervousness." Noyes[6] defines it this way: "Relatively benign group of personality disturbances which are often described as being intermediate between various adjustmental devices unconsciously utilized by the average mind on one hand and the extreme, often disorganizing methods observed in the psychotic on the other." Definitions such as these are obviously lacking in any distinctness and it is easy to see why these terms

5. Garber, S. T.: Stedman's Medical Dictionary, Williams & Wilkins, Baltimore (1942).

6. Noyes, A. P.: *Modern Clinical Psychiatry*, Saunders, Philadelphia, p. 445 (1952).

are used so loosely both by laymen nad physicians. Practically speaking, it was sometimes difficult to make an objective diagnosis of neurosis if one didn't use the assistance of these above named factors.

FINDINGS

THE largest number of patients were in the cardiovascular group—18.5 per cent of the total patient load. The "neurotics" accounted for 17 per cent of the total. If this is a typical figure, neurotics must constitute a large portion of the doctor's practice, but do not a majority of his practice.

These proportions suggest that general medical practice is a conglomeration of many diseases of which the "pure functional" or "neurotic" comprise only 17 per cent; or in combination with the psychoses total 19 per cent. Emotionally disturbed patients form one of the largest groups in the general office population but fall short of the figures of 30 to 70 per cent frequently quoted.

INTERPRETATION

MANY possibilities might explain this apparent discrepancy in figures. The dichotomy between "psychoneurosis" and "organic disease" is a perilous one. It attempts to divide the person into segments. This is unsound, because the individual is a combination of emotional reaction as well as organic dysfunction; and the resulting disease is a combination of these two plus many other variables. Likewise, the broadness of the interpretation is dependent upon the point of view of the interpreter. Some physicians are oriented to the concept of psychosomatic ailments such as asthma, hay fever, migraine, ulcerative colitis, hypertension, peptic ulcer and obesity. Although these diseases are affected in various degrees by stressful situations, they have never been proved by the postulates of Koch to be caused by emotional factors. There is still a large and nebulous group of conditions in which the etiology is multiple and obscure and in which stress may aggravate or produce relapse. Until we can produce such disease experimentally or show without confusion its production in human life, it will have to remain in the unknown etiologic category. For the purpose of this discussion, these diseases are considered "organic" because of the obvious changes that occur in organs that can be demonstrated by objective means.

Some categories in this study are subject to re-evaluation depending on the criteria used by the physician. Many obese females came to the office for dietary control and weight reduction. Some physicians stress a direct relationship between obesity and emotional disturbances that may be partly correct; but most obese individuals in my experience are those who overeat because the food and drink are available, tasty and satisfying.

Other sources of error may account for the apparent discrepancy between my figures and those of the quoted authors. Superficial and hurried diagnostic methods are more prone to result in the placement of certain obscure diseases into the category of psychoneuroses. Too often, the term "functional" means that demonstrable defect, either macroscopic or microscopic, cannot be identified by the available diagnostic tools of medicine. The usual office patient should have an exhaustive history and a meticulous physical examination as well as a few key diagnostic tests such as x-rays, blood work and urinalysis; but this goal is not always achieved under the pressure of busy practice and multiple responsibility. The practitioner acts as a higher educated screening mechanism to attend the greatest number of individuals expeditiously in terms of time and money. Both major and minor ailments are treated effectively in most cases but many of the "problem cases" consist of diagnostic problems, therapeutic failures, psychoneurotics and combinations of these. The frustration associated with these conditions obscures the picture so that one category becomes indistinguishable from the other. For example: Headache due to an obscure undiagnosed brain tumor may be attributed to marital incompatibility which is also present. Only after exhaustive tests as well as the passage of time

does the organic lesion become recognized; but the patient may be tagged as a "neurotic" until the facts are clear.

Some patients are incorrectly classified and treated for "neurotic disorders" who have organic disease disguised by a neurotic reaction. Here, for instance, is an early progressive organic disease masked by neurotic behavior and set in an environment of neurotic growth which eventually blossomed forth as recognizable organic disease.

A 54-year old woman had been seeing physicians regularly for the past fifteen years because of "indigestion," palpitations, weakness, chest distress, pain in the legs, and pain in the arms. The symptoms had started shortly after the death of her husband, at which time she had to return to work to support her two children. She had to assume the full responsibility because her husband had failed to provide insurance coverage and death benefits. She had two sisters who were severe hypochondriacs, as was her mother.

The patient started to make the round of physicians used by her family and received a plethora of placebo and semi-placebo therapy. Electrocardiograms were normal on numerous occasions, although at no time was a "two-step test" performed. X-ray of the gastrointestinal tract revealed a diverticulum of the second part of the duodenum but this was considered to be asymptomatic. No ulcer or gall bladder disease was found. The patient continued to work at full time factory labor and lost only minimal amounts of time because of illness. After almost ten years of "hypochondriacal" complaining, she was given sublingual nitroglycerin and the improvement, although temporary, was significant. In 1954, she suffered her first typical acute myocardial infarction with electrocardiographic changes. She then had a hypercholesterolemia as well as the changes associated with an acute infarction.

The patient made a normal recovery and returned to work. She still complained of "recurrent angina" as well as typical intermittent claudication. One year later, she suffered another massive acute myocardial infarction, almost fatal. She experienced *status anginosus* and it was decided to use radioactive iodine therapy with the hope of alleviating pain. Following the second acute infarction and prior to the use of radioactive iodine, she suffered almost continuous angina. Various tranquilizers were used since it was suspected that anxiety was triggering or inciting this angina. At no time did the patient demonstrate any remarkable improvement even though her anxiety was alleviated to the point of abject drowsiness. With the use of radioactive iodine and a decrease in the euthyroid state to a hypothyroid state, the angina decreased so that she was able to return to full activity.

This patient demonstrates the manner with which "neurotic" behavior may disguise organic disease; and yet it is the organic disease that required most of the treatment. When the organic disease was successfully treated, the patient's "neurotic" complaints were benign and compensated. Only when the organic symptoms were unrelieved did the neurotic segment decompensate, producing the composite picture of a disturbed psychoneurotic. It is probable that so many organic diseases in their infancy remain disguised for months or years so that the recognizable neurotic reactions obliterate the entire picture. Neurotic individuals suffer from organic disease, but because of their neurotic background and behavior they are frequently improperly treated.

CONCLUSIONS

THIS study of 1,054 patient visits to the office of an internist was an attempt to evaluate the proportion of various diseases seen in an average ambulatory practice with special scrutiny of those considered neurotic or functional. The current literature does not contain any exhaustive studies of this nature, although many references [1-7] are made to the large numbers of neurotic individuals supposedly seen in the usual non-psychiatrist's practice. The purely or predominantly neurotic patients seen and tabulated by this present limited study amounted to 17 per cent, which is much smaller than anticipated. Possible sources of discrepancy between this latter figure and the frequently quoted (30 to 70 per cent) may be due to: (a) broader interpretation of a neurotic disease including psychosomatic disorders such as asthma, hypertension, peptic ulcer, ulcerative colitis, and obesity; (b) hurried and inadequate diagnosis; (c) problem cases; (d) therapeutic failures; (e) neurotic individuals with organic disease; (f) chronic organic disease disguised and encrusted by neurotic reactions. It is the considered opinion of many authorities [6] that the figures so frequently quoted (30 to 70 per cent) are merely

7. Editor: *Factor* (Professional News Bureau), New York; 1:14 (1959).

an educated guess because of the glaring absence of objective statistical studies.

The problem of dealing with the neurotic or functional disease is seen most frequently by the internist and general practitioner. There is a great need at this time for a country-wide study at the internist and family doctor level involving practitioners using a standard criterion of diagnoses as well as certain objective psychologic tests. It is only after exhaustive studies that this present pilot study will be confirmed or rejected.

133 West Jersey Street

Society for the Relief of Widows

The Trustees of the Society for the Relief of Widows and Orphans of Medical Men of New Jersey are proud to announce that Mrs. Cadwell B. Keeney of Summit, N. J. and Mrs. Elmore G. Brittain of Clearwater Beach, Florida, have assigned their interests in the benefits from the Society due them upon the death of their husbands. These moneys have been placed in the permanent fund for investment, the interest from which is used for relief of needy widows. Both Mrs. Keeney and Mrs. Brittain have been designated "Benefactors" and their names enscribed on the rolls of the Society.

A current financial statement for the Society follows:

Balance on Hand—May 1, 1959	$ 9,804.49
Receipts—Assessments, interest, etc.	9,464 77
	$ 19,269.26
Disbursements—	
Widows	6,509.20
Permanent Fund	1,120.00
Supplies, moving expense, bank charges, etc.	1,784.65
Addressograph machine	405.00
Total Expenditures	$ 8,698.85
Cash on Hand—April 30, 1960	$ 10,570.41

The status of the Permanent Fund is as follows:

Cash on Hand—May 1, 1959	$ 4,586.51
Income—Stocks and bonds	3,956.16
From Contingent Fund	1,120.00
	$ 9,662.67
Disbursements—	
Donation to four widows	$ 2,700.00
Transferred to Capital Fund	1,120.00
	$ 3,820.00
Balance on Hand—April 30, 1960	$ 5,842.67

MAY 1, 1960

Inventory of Securities—	
Common stocks	$ 47,870.00
Preferred stocks	5,550.00
Municipal-Industrial bonds	29,700.00
U.S. bonds	26,280.00
Cash on Hand	77.88
	$109,477.88

Further information about this unique helping-hand organization may be obtained from its president, Dr. Earl LeRoy Wood, 225 Ballantine Parkway, Newark 4, N. J.

Ralph A. Hall, M.D.

Westfield

The Audio-Frequency Generator as a Practical Diagnostic Instrument for the Doctor's Office

Offered here is a novel suggestion that a measurement of audio-frequency hearing level should be part of a routine physical examination. Dr. Hall thinks that a low hearing level may be a pilot of arteriosclerosis.

Modern interest in high-fidelity equipment led to the routine measurement of maximum audio-frequency hearing levels of all patients coming into my office for physical examinations. This figure is definitely of interest to many of the patients who are interested in high-fidelity instrumentation. Low-priced kits and packages of audio-frequency generators [1] make this measurement practical for every office. A slight modification of the usual kit to accommodate good quality binaural ear phones [2] makes it possible to compare hearing in each ear separately. Such machines are accurate within five per cent, which is within the limits of human error for such a measurement. The measurement is reliable, easily taken, and readily communicated. Here is a discreet measurement that takes no long training to learn to make. Other machines are expensive and many of them measure only those frequencies below 9,000 cycles per second. These are not suitable for this experiment.

A well established relationship regarding this measurement is its relationship to age. As one gets older, the maximum audio-frequency hearing level gets lower. This is said to be due to chronic endarteritis of the cochlear arterioles. The finer perceptive areas go first and leave the patient with less ability to hear high frequencies. We have here then, one more measurement to consider along with everything else in our estimate of the aging process.

Five-hundred-twenty-six patients of all ages with the sole limitation, the ability to comprehend and cooperate were measured. The youngest was ten and the oldest was eighty-four. Data were separated according to sex, then graphed against age. It was immediately evident that the decline of maximum audio-frequency perception and the limits to perceive it were essentially the same in both sexes.

Two measurements were made on each patient. The minimum perception of the tone cycle No. 440 corresponding to the orchestral pitch A. These machines usually have a satisfactory attenuation dial with arbitrary numbers that can be recorded for comparison. This was a good measurement for hearing acuity. The other measurement was the maximum number of cycles per second audible at minus twenty decibels on the machine. When it was louder, patients were conscious of some type

1. I use the Knight Audio Generator, model 337-K distributed by Allied Radio of Chicago.

2. For example, Brush binaural crystal earphones.

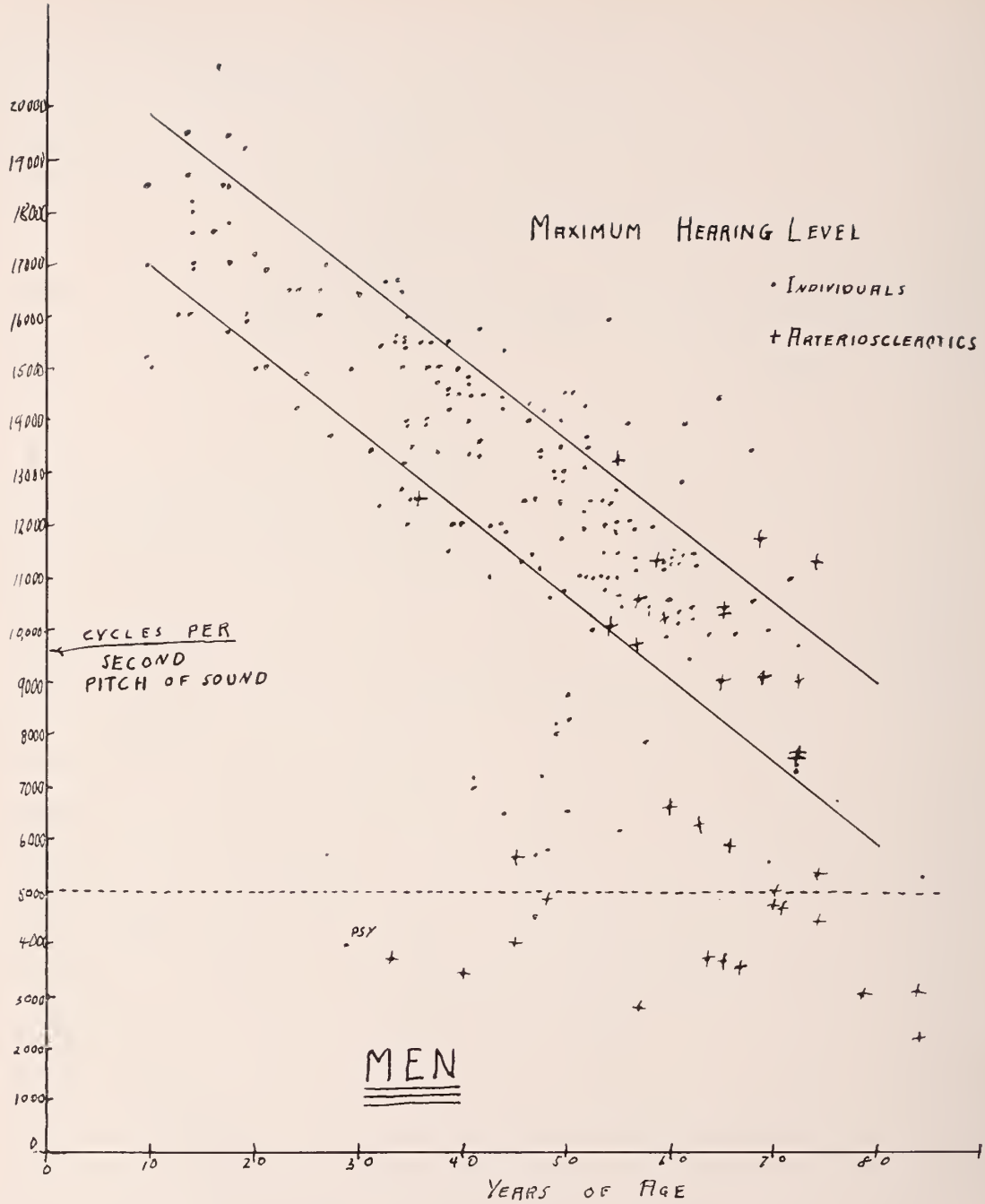


Figure 1. This chart represents 245 men, 36 of whom have evidence of arteriosclerosis. Note that all with a maximum audio-frequency hearing level below 5000, regardless of age show some pathologic arteriosclerosis. PSY identifies a patient who was then receiving psychotherapy. Patient at a e 47 with hearing level of 4800 was an uncontrolled diabetic.

of air-conducted energy even after their upper tone limit had been exceeded. The reading then becomes valueless.

As the data were being collected, I became vaguely conscious of a relationship between circulatory disorders and the highest audio listening level. When these cases were designated by a plus sign on the chart, they seemed to fall into a pattern. If this turns out to be reliable, it may be of considerable practical

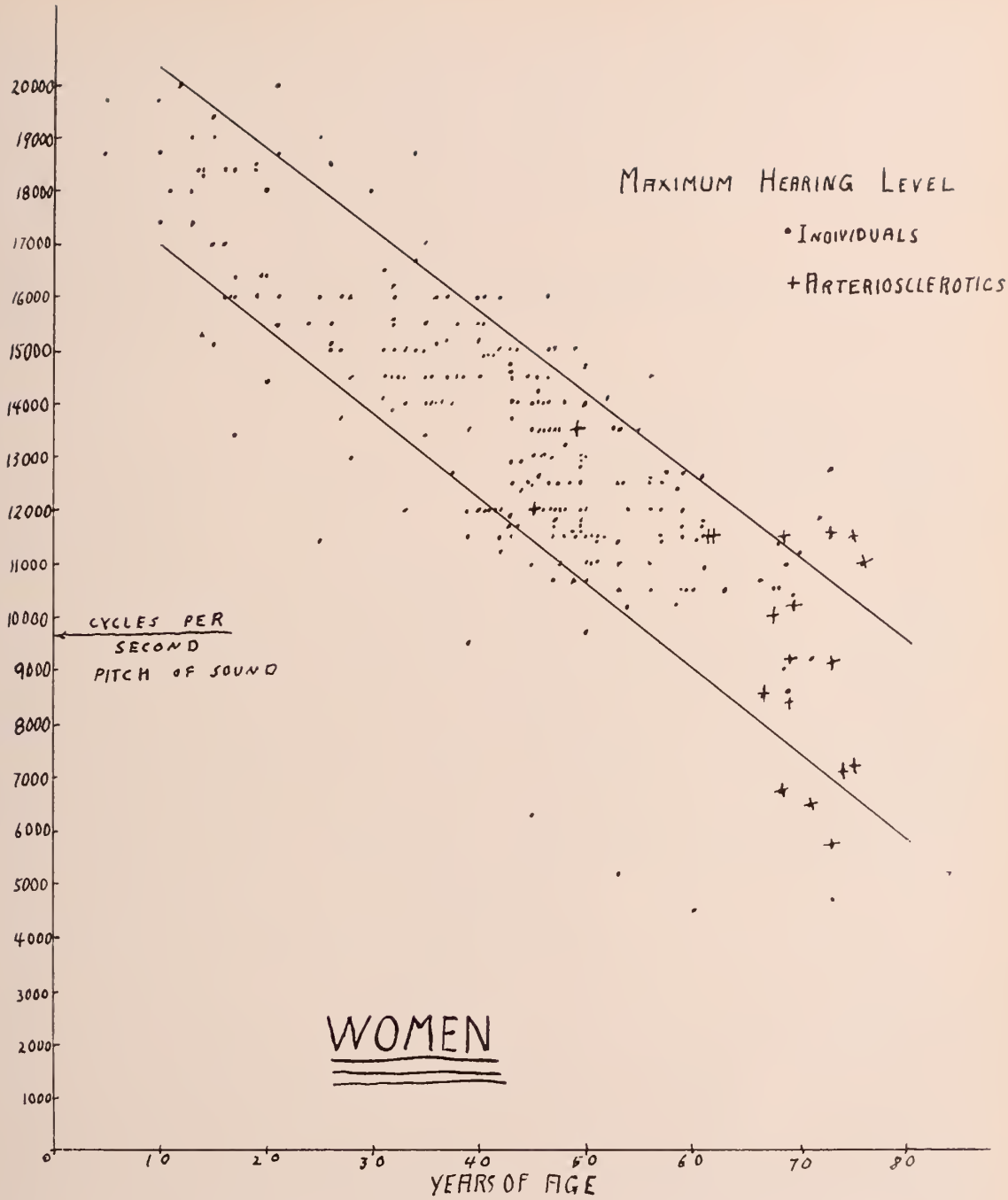


Figure 2. This chart represents 281 women, 19 of whom have evidence of arteriosclerosis.

value to the general practitioner. I am fully aware of the pitfalls of enthusiastic and biased investigations dealing with insufficient sampling, and therefore timidly present these observations for others to contemplate and to confirm or deny.

The group studied here are those who report for complete physical examinations. They are by no means representative of the entire population. People that have had an arteriosclerotic "vascular accident" seek medical advice more frequently than those who have not. Younger people stay away because they feel strong, smooth, elastic, limber and free of

pain. Children appear only because their parents bring them. Older people have not been educated to seek routine physical examinations. They ask: "What is the use?" So this is probably an average medical office practice. Of this group, 53.5 per cent are women. Of the men, 15 per cent had vascular conditions as against 6.6 per cent of the women.

245 men,	46.5%;	36 vascular cases—14.7%
281 women,	53.5%;	19 vascular cases— 6.6%
526 total,	100%	

In each case an exhaustive medical history was taken. Each patient received a meticulous physical examination including an electrocardiogram, a flat x-ray of the abdomen, and fluoroscopy of the chest. Any evidence of an atherosclerotic condition such as calcified arteries in the chest or abdomen was tallied. A reliable history of "vascular accident" was also counted.

A glance at the graph for men reveals that a low audio-frequency hearing level regardless of age is highly significant. Here we see that *nearly all subjects with a maximum audio-frequency hearing level below* 5,000 *have evidence of arteriosclerosis.* Among the men in this classification were two exceptions. One was a psychoneurotic under treatment with a psychiatrist. The significance of this is not understood. The other exception: one with a reading of 4800 at age 47 who was an uncontrolled diabetic at the time the reading was taken.

This is an effective case finding procedure. A patient who loses a perceptible number of cycles in a short time gives evidence that something is going wrong. A woman who lost 4000 cycles in one year without suspecting it was given large amounts of vitamin A with prompt improvement. Also there was an unexpected improvement in her sense of well being.

SUMMARY AND CONCLUSIONS

1. Measurement of the maximum audio-frequency hearing level confirmed its well known relationship to age.
2. A highly suggestive relationship was shown between pathologic arteriosclerosis and a low hearing level in men.
3. Otic neuritis due to avitaminosis and diabetes was discussed as a problem to be measured by this method.
4. The audio-frequency generator is an economical and practical diagnostic instrument for office practice.

547 E. Broad St.

Big Ears

Protruding or abnormally large ears, usually the object of ridicule, can be corrected by a relatively simple surgical procedure, reports Jones.*

Such abnormalities often have an unfortunate effect on the patient's personality. They are the object of jest, sarcasm or satire. Children with protruding ears are teased. And teasing from playmates "results in personality changes, occasional aggressiveness, or even bumptiousness, but more often shyness and retirement."

Dr. Jones describes a surgical technic for the correction of this deformity and recommends that the operation be delayed until the ear is fully developed (usually at the age of 5 years).

The ear specialist, he said, "should think no more of correcting protruding ears than an orthopedist does of correcting clubfoot, or an ophthalmologist (eye specialist) does of correcting ptosis (drooping) of the eyelids."

*Jones, E. H.: Operation for correction of protruding ears, *Southern Medical Journal*, 52:1067 (September) 1959.

Catalino Arenas, M.D.

Robert J. Ryan, M.D.

Trenton

Influence of Protein Diet on Blood Volume*

A close correlation between protein in the diet and subsequent blood volume is demonstrated in this simple but careful study from the St. Francis Hospital in Trenton.

The effect of diet on blood volume is well appreciated on the clinical level. This is a report of a research project which sought, in an objective manner, to determine the nature of this relationship.

In 1950, Murphy[1] demonstrated the effect of rice diet on plasma volume and hematocrit. There was a mean decrease of 15 per cent in blood volume on this diet. In 1958, Pareira, Sicher and Lang[2] showed the effects of acute and chronic starvation and protein-free diet on blood volume. Blood volume declined appreciably in all three classes. The ratio, however, of blood volume to actual body weight was essentially stable. Serum protein levels declined only in protein-free class. The arterial hematocrit rose in acute starvation, remained essentially stable in chronic undernutrition but declined rapidly in protein-free diet. The unreliability of hematocrit in relation to blood volume has also been shown by the Army.[3]

METHODS AND MATERIAL

Seven rabbits were placed on a virtually non-protein diet of potato skins, lettuce and water. The analysis revealed this contains 0.1 Gram protein, 0.3 milligrams of iron and 7 milligrams of ascorbic acid per portion. Forty days after this regimen, blood volumes were done on each rabbit using the Congo Red technic. During this procedure which required cardiac aspiration of 3 cubic centimeters of whole blood, three rabbits were lost.

Thereafter the remaining four rabbits were placed on a 23 per cent crude protein diet supplemented with vitamins and Brewer's yeast for 40 days. Again blood volumes were attempted but three more rabbits were lost.

RESULTS

After 40 days on a virtually non-protein diet the following hematocrits and blood volumes were obtained.

Animal	Hematocrit Per Cent	Blood Volume Cubic Centimeters
C	33	30
D	32	40
E	26	42
F	39	56

*This work comes from the St. Francis Hospital where Dr. Arenas is resident in surgery and Dr. Ryan is on the surgical staff.

1. Murphy, Richard: Journal of Clinical Investigation, 29:912 (1950).
2. Pareira, Morton, Sicher, Nellie and Lang, Stanley: Archives of Surgery, 77:191 (1958).
3. Crosby, William: U. S. Armed Forces Medical Journal, 9:1456 (1958).

The sole survivor on the high protein diet showed a hematocrit of 41 per cent and blood volume of 67.5 cubic centimeters.

CONCLUSIONS

THIS study, while too limited to be significant, again indicates the relationships between low protein diet and blood volume. The average blood volume on the protein-poor diet was 42 cubic centimeters while the rabbit that survived the second cardiac puncture and was on a high protein diet had a blood volume of 67½ cubic centimeters.

717 Hamilton Avenue (Dr. Ryan)

Diet Manual Available

A diet manual prepared with New Jersey physicians as advisors is having significant impact on diet preparation in institutions and for individuals. Any physician may secure a copy from the New Jersey Department of Health, 129 East Hanover Street, Trenton 25. To date some 3,000 physicians have requested copies.

As the preface says, "the manual was written for use by physicians, dietitians, and nurses in the hospitals and nursing homes of New Jersey. It represents the modern trend in diet therapy and is based on opinions of leading authorities in the field. Nutritional needs of the patient and simplicity in planning have been considered . . . Much thought has been given to nomenclature. Exact nomenclature avoids confusion and helps to evaluate the results of diet therapy . . . Names of diseases have been avoided where possible so that the patient need not be reminded of his illness."

The *New Jersey State Diet Manual* was prepared by the Diet Therapy Committee of the New Jersey Dietetic Association aided by a Medical Advisory Committee appointed by The Medical Society of New Jersey. Others assisting in the preparation were the former Dietary Consultant of the New Jersey Hospital Association and the State Consultant in Public Health Nutrition of the State Department of Health.

The manual is dedicated to Dr. S. William Kalb, of Newark, a member of the Medical Advisory Committee.

Prior to printing, diets were reviewed and approved by medical specialists and by the New Jersey Dietetic Association. Funds were made available by the United States Public Health Service.

Several joint meetings of the Dietetic Association and The Medical Society of New Jersey were held during the preparation of the manual. County medical societies were invited to send representatives to these meetings and nineteen of them did so.

A copy of the manual has been sent to each hospital and nursing home in New Jersey, to the administrator of each State institution, and to county homes for the aged. With the approval of the Department of Institutions and Agencies, State hospitals have adopted this publication as their official diet manual. Several private hospitals, with the approval of their medical staffs, are now using it as their official diet manual.

The manual gives recommended daily dietary allowances of the Food and Nutrition Board of the National Research Council; normal diets; routine hospital diets; diets for children; diets for pregnancy and post-pregnancy; diets for older persons; diabetic diets; low calorie diets; sodium restricted diets; fat restricted diets; materials on tube feedings; tables showing sources of minerals, vitamins and recipes.

Samuel A. Sandler, M.D.

Hackensack

Psychiatric Symptoms in Brain Tumors*

Patients with emotional symptoms are seen by general practitioners daily. With shocking frequency, as Dr. Sandler here shows, these "psychiatric" symptoms may turn out to be manifestations of brain tumor, often responsive to swift surgery.

It has been known for years that patients with brain tumors may show personality changes; but it is less generally understood that sometimes the only symptom of a brain tumor may be a psychiatric one. Often, a psychiatric symptom precedes an organic neurologic sign by months and years, especially if it is a slow-growing tumor. The brain has the facility of adjusting or accommodating itself to an expanding slow-growing lesion. The first symptom (psychiatric or organic) may follow severe *emotional* trauma to the individual. The first psychiatric symptom may take the form of a psychoneurosis or a psychosis. Neurotic symptomatology may manifest itself as anxiety, depression, "hysteria," or irritability. The psychotic symptom may resemble schizophrenia, a confusional state, dementia or a manic depressive psychosis. A meningioma arising from the olfactory groove and involving the frontal lobe may be present for years without any objective organic signs other than impairment of the senses of smell. It is most important to detect this type of tumor because they are usually surgically accessible; and removal generally leads to excellent results.

Many cases of so-called confusional state, behavior disorder, dementia, and hallucinations are due to tumors in the temporal lobes. Sometimes they are not properly diagnosed because of the inability of the patient to communicate due to his aphasia. Too often, the patient does not receive an adequate neurologic examination. Many general practitioners have a resistance to or an unawareness of the usefulness of the electroencephalogram. This instrument has achieved a high degree of reliability in facilitating the diagnosis of brain tumor. Confusion may be caused by spatial disorientation associated with a visual field defect. On occasion the patient's poor memory may result from a "word-finding" difficulty caused by aphasia. The careful study of a so-called case of dementia may reveal it is an apractic disorder. Visual hallucinations may not stem from either a delirious state or a psychosis, but may be due to a disorder of sensory perception such as in occipital lobe involvement. A temporal lobe tumor may lead to severe behavior disturbances, amnesia, and many types of abnormal sensory perception. A patient with a temporal lobe tumor may have a convulsive disorder and yet not be aware of this problem. During or after such an episode (a convulsion) the patient may have a "maniacal" attack, with clouding of the consciousness, irritability and confusion.

The physician is taught that personality changes may result from some impairment of the cerebrum; yet there is scant reference in the literature or in neurologic textbooks regarding mental changes resulting from brain-

*From the Neurologic Service of The Bergen Pines Hospital, Paramus, New Jersey.

stem tumors. Keshner, Bender, and Strauss† point out that in their series of nineteen patients with brain-stem tumors, mental symptoms were present in eleven patients: that is in 55 per cent! Disturbances were severe and characterized by marked apathy, drowsiness, and torpidity. One patient was almost constantly in a semi-stuporous state. Six had disturbances in affect. Of these, three were children who were hyperirritable, lacrimose, and depressed. Two adults were euphoric.

In "ball valve" tumor of the third ventricle, patients complain of excruciating headaches and act "hysterically"; when they change their position, they become fairly comfortable which leads the unskilled examiner to assume that the whole picture is "emotional."

The picture of headaches, impairment of memory, or confusion in a fifth decade or older patient, is apt to be diagnosed by a careless or hurried physician as cerebral arteriosclerosis if the patient is male. If the patient happens to be female, the physician may decide that the symptoms may be due to the "involutional period." Such a patient may have a brain tumor.

CASE ONE

A 69-year old woman had six daughters. She came to my office complaining of "butterflies in my stomach." She was irritable and felt confused. She complained of insomnia, and said she had alternate feelings of being hot and at other times being cold. She also added that she felt tremulous and had generalized paresthesia. Persistent questioning revealed that six weeks previously her husband had approached her sexually and she refused him. The husband went into a rage and gave her the worst tongue lashing that she ever had in 48 years of marriage. She ran out of the bedroom and was so upset that she was unable to sleep the rest of that night. She stated, "I was never so disturbed or humiliated in all of my life."

Careful neurologic examination was negative for any organic disease of the central or peripheral nervous system. I saw her several times later for psychotherapy and she appeared somewhat improved. Three months later she suddenly developed a hemiplegia. She was admitted to a New York hospital and at operation, a glioblastoma was found in the right temporal region.

Her first and only symptom was a picture strongly suggestive of a depression. The lesson to be learned from this case is that when a patient has reached the sixth decade of life and has never had any neurotic symptoms before, it is quite possible that the patient's depression or other psychiatric symptoms might be due to an organic lesion. Perhaps it is necessary in such a situation that the examiner insist upon an electroencephalogram as a further aid in diagnosis to rule out the possibility of an organic cerebral lesion. This case is also of added interest because emotional trauma brought out the first symptomatic reaction to her brain tumor.

CASE TWO

A 53-year old unmarried woman was admitted to Bergen Pines Hospital with a history of numerous psychotic episodes for which she had been committed to a state mental hospital. Her first admission to this hospital was 13 years earlier. At that time she was confused, irritable, disturbed and tense. She would talk spasmodically and occasionally incoherently. She had "wild delusions" and "slight hallucinations." This cleared up but 8 years later she began to have convulsive seizures. She was admitted to a New York hospital where a meningioma was found in the left middle fossa in the temporal lobe area. Following her operation she did fairly well for about one year. Then she began to have disorganized delusions, was exceedingly irritable, seemed confused, and talked to herself constantly. Under chlorpromazine and diphenyl hydantoin, she did very well for a few more years until she was admitted to Bergen Pines for convulsive seizures. She died 7 months later. At autopsy a massive meningioma was found along the base of the brain.

The patient's first "organic" symptom was a convulsive seizure eight years after the beginning of her psychiatric symptoms.

CASE THREE

A 51-year old spinster was admitted to the Psychiatric Department of Bergen Pines Hospital. She had been acting "strangely" for the past two years. She had shown signs of progressive mental deterioration principally in her personal hygiene. She would laugh inappropriately and did not seem to understand what was being said to her. She had periods of depression and confusion. Aphasia and apraxia were present. On neurologic examination, I found a blurring of the optic disc margins, greater in the left, and a left Babinski. Ventriculogram revealed an extensive mass lesion on both sides of the midline. The mass caused a downward displacement and spreading apart of the anterior horns. The third ventricle and the frontal horns were displaced to the right. X-ray diagnosis was corpus callosum glioma. Electroencephalogram showed changes compatible with organic pathology involving the frontal lobes bilaterally. The

†Keshner, Moses, Bender, Morris and Strauss, Israel: Archives of Neurology and Psychiatry, 35:572 (1936).

patient died two months after admission. No autopsy was permitted.

This woman had the symptoms of a presenile dementia and not until she was examined neurologically (after admission to the hospital) was a brain tumor suspected.

CASE FOUR

A 67-year old woman was admitted to Bergen Pines Hospital ten months after she first began complaining of vertigo, nausea, speech difficulty, insomnia, burning sensations on the scalp, and fainting spells. She was given tranquilizers with considerable improvement. She had lost interest in her home, showed confusion and memory impairment, had difficulty in walking and appeared depressed. She was disoriented for time and place. Pupils were sluggish to light. She had difficulty with upward gaze. The fundi were within normal limits. X-ray of the skull was normal. The patient became comatose. Emergency ventriculography was followed by right frontal craniotomy. A tumor of the third ventricle was removed. The patient never regained consciousness. No autopsy was permitted.

This patient was considered a "depression" and seemed to improve on tranquilizers. When medication was discontinued, her improvement was maintained for four more months. Then her symptoms became accentuated. The point is that with a brain tumor, symptoms may temporarily show improvement or even apparent recovery. This turns out to be only a mirage.

CASE FIVE

A 52-year old woman was admitted to the Psychiatric Service of The Bergen Pines Hospital. She suffered from headaches for two years. Then she became more and more "withdrawn" and showed no interest in her appearance or environment. She had frequent periods of depression. She acted listless. Memory was poor. At times she seemed confused. Frequently she wandered around, pacing the floor. She began to sleep a great deal and would refuse food. She became very seclusive. Diagnosis on admission was a depression associated with a Parkinson syndrome.

The fundi showed retinal hemorrhages. She had a right central facial weakness, a positive right Hoffman and a right neutral plantar reflex. Spinal tap revealed clear fluid with a pressure of 360 millimeters of water. Protein was 60 milligrams per cent. A diagnosis of a left fronto-temporal brain tumor was confirmed at craniotomy. Histologic diagnosis was glioblastoma multiforme.

This presents a new problem. When placed on phenothiazine derivative tranquilizers, many patients develop extrapyramidal or Parkinson syndrome. This was true in this case.

CASE SIX

A 35-year old man was admitted to Bergen Pines Hospital in a comatose condition. Six weeks prior to admission, the patient suffered from anorexia, severe headaches, vomiting, and confusion. One month later a psychiatrist made a diagnosis of a depression and the patient was treated accordingly.

His blood pressure was 90/60. The pupils were dilated and did not react to light. Examination of the fundi revealed flattening of the discs bilaterally with retina of a normal character. Spinal fluid pressure was 360 millimeters of water. A diagnosis of cerebral neoplasm was made. The man died three hours after admission. On autopsy, infiltrating glioblastoma multiforme was found with massive hemorrhage involving the right temporal and frontal regions of the brain.

This presents the phenomenon in which a brain tumor produced fulminating psychiatric symptoms so severe and rapid that the patient died within six weeks.

CASE SEVEN

A 57-year old man was admitted to The Bergen Pines Hospital, insisting that people were stealing money from him and that his wife was unfaithful. He threatened to kill her. He would wander aimlessly in his community half-dressed. He was profane, argumentative and assaultive. He showed signs of aphasia and poor judgment. These symptoms were a repetition of those which caused him to be hospitalized in New York City a year earlier. At that time a neurosurgical study revealed evidence of a brain tumor. On craniotomy, an astrocytoma was found involving the right temporal, parietal, and occipital regions. The tumor was partly removed. Following the operation, he did very well for a few months and then became confused and paranoid again. On admission to Bergen Pines, he had a left facial asymmetry. Pupils were equal, reacting sluggishly to light. He had atrophy of the optic discs. There was a weakness on the left and lower extremities. There was a left neutral plantar reflex. Our admitting diagnosis was paranoid reaction in a patient previously operated on for a cerebral neoplasm.

This case exemplifies a severe psychiatric problem manifested by antisocial, belligerent, and paranoid activity precipitated by a brain tumor.

CASE EIGHT

A 57-year old man became very listless. He refused to work. When he spoke, he was unable to complete a sentence. He complained of numbness in his right hand. Vision became so impaired that he would occasionally bump into objects. He developed weakness of the right upper and lower extremities ten days before admission.

A year before he had been in an automobile accident. There was no history of hospitalization or loss of consciousness following this. He did, however, develop headaches which lasted as long as three days. On neurologic examination the patient showed the following: blurring of both discs with flame hemorrhages in the right retina and disc; right facial asymmetry; weakness of right upper and lower extremities; right neutral plantar reflex; deep reflexes were greater on the right than on the left; there was evidence of aphasia and apraxia. Shortly after admission, craniotomy revealed a metastatic carcinoma to the left temporo-parietal region of the brain, probably of pulmonary origin.

This case presents a common problem in which automobile accidents with no apparent serious consequences are presumed to be the cause of all subsequent symptoms and illnesses. From the history one could have been easily misled into assuming that the patient's psychiatric symptoms were due to a subdural hematoma following the automobile accident. But neurologic examination established a diagnosis of a cerebral neoplasm involving the right frontal, temporal, and parietal areas, which was confirmed at operation.

SUMMARY

1. Mental symptoms may be the first and earliest manifestation of a brain tumor and may precede organic neurologic signs by months or years.

2. Any type of psychiatric syndrome (neurotic or psychotic) may appear in the course of a cerebral tumor.

3. If a patient has headaches, memory defects or personality disturbances which persist for an extended period, x-rays of the skull and electroencephalography should be done.

4. A small hemorrhage into a cerebral neoplasm or compression of a blood vessel by a brain tumor may provoke acute psychotic behavior.

5. No patient should be committed to a psychiatric institution without a neurologic evaluation being done first.

6. Any patient over 30 years of age who shows personality changes associated with a convulsive disorder should be considered a brain tumor suspect until proved otherwise.

254 Union Street

Rock, Roll and Rhythm

Seeking to interpret Rock 'n Roll, Meerloo,* a New York psychiatrist, argues that this is a kind of mass neurosis which resembles the "dance manias" of the Middle Ages. Rhythm is an embryo's first sensory experience. It hears its mother's heart-beat syncopating against its own heart-beat in a 1-to-2 ratio. Thus the beat of music awakens memories of that first home. Rhythm this way mobolizes our body's epinephrine and arouses dormant memories of prehistoric man when the tom-tom and the tribal drums communicated primitive emotion.

*Meerloo, J. S.: American Practitioner, 10:1029 (June) 1959.

The Weaker Sex

Women tend to have more operations than men, according to *Patterns of Disease*, a Parke, Davis and Company publication. About 46 operations per 1,000 women are recorded annually in short term hospitals, exclusive of deliveries. The rate of men's operations is 38 per 1,000. By far the commonest type of operation is the tonsillectomy and/or adenoidectomy, of which 16 for every 1,000 persons were performed in 1957-58. Next are appendectomies, with 6 operations for every 1,000 persons performed during the same period.

KENNETH JORDAN, M.D.†

Montclair

The Relief of Muscular Spasm and Pain in Orthopedic Conditions

A muscle relaxant with analgesic properties is here found to be an excellent medication for a variety of orthopedic disorders characterized by pain and muscle spasm. Low doses and absent side-effects were added features in this careful study by the late Dr. Jordan.

PAIN and spasm of skeletal muscles are among the most common symptoms seen by the orthopedic surgeon. Need for the relief of these disabling symptoms has occupied the attention of clinicians and research workers for a long time. Despite intense interest in the problem, no completely satisfactory solution has been found, and the search continues. Recently, a new drug with analgesic and muscle relaxant properties has been developed; its characteristics as shown in the laboratory indicated that it deserved a clinical trial.

Carisoprodol* is, chemically, n-isopropyl-2-methyl-2-propyl-1,3-propanediol dicarbamate. It was synthesized by substituting an alkyl group for one hydrogen on one of the amino groups in the meprobamate molecule. When the resultant derivative was tested in the laboratory on decerebrate cats, its unusual muscle relaxant properties were revealed.[1] A dose of 3 milligrams per kilogram eliminated the high voltage spikes of spasticity. Mephenesin and meprobamate could produce equivalent effects, but only when the dose was 24 milligrams per kilogram. Carisoprodol,* therefore, appeared to have about 8 times the muscle relaxing effects of mephenesin and meprobamate.

The analgesic effects of carisoprodol* were tested on rats whose ankle joints had been injected with silver nitrate. Flexion of the injected joint produced pain which could be measured for intensity. Carisoprodol* effectively relieved this pain in doses that did not produce toxic symptoms. Aspirin, on the other hand, was effective only if given in doses which were lethal to some of the animals. Unlike morphine and other powerful analgesics, laboratory tests showed that carisoprodol* did not abolish the reflex defense withdrawal response. Thus, it appears that the drug can modify central perception of pain without abolishing the reflex defense withdrawal response.

Tests have shown that carisoprodol* has about the same acute toxicity as meprobamate. Chronic toxicity tests have shown no significant reactions in rats whose diet contained up to 2 per cent of the drug for one year.

With this pharmacologic data in mind, the following clinical study was made in an orthopedic practice.

---

†Dr. Jordan died November 10, 1959. Reprints of this paper may be obtained from William A. Davis, M.D., 270 Ridgewood Avenue, Glen Ridge, N. J.

*This is tradenamed by Wallace Laboratories of New Brunswick, N. J., as Soma®.

1. Berger, F. M. *et al.*: Journal of Pharmacologic and Experimental Therapy, 127:66 (September 1959).

PROCEDURE

To determine the value of carisoprodol* as a muscle relaxant and analgesic agent, the drug was given to 136 orthopedic patients. In the group were 54 males and 82 females whose ages ranged from 8 years to 93 years with an average age of 40. Diagnoses of these patients, together with the number of cases of each, is shown in Table 1. Twenty-two of the conditions were chronic, and 114 were acute or acute exacerbations of a chronic illness.

The initial dosage for 84 of the patients was one 350 milligram tablet of carisoprodol* three times a day; 25 hospital patients were given a 400 milligram tablet four times a day, and 27 office patients received 400 milligrams three times a day. These minor variations in dosage did not produce appreciably different results. During the two-week study period, the patients received no other medication for the disorder for which carisoprodol* was being given.

Though no controls were used, many of the patients with chronic disorders had been treated with other drugs for long periods of time prior to this study. The evaluation of the responses of these patients is based on a comparison of their reactions to carisoprodol* with their reactions to previous therapy.

In the evaluations for this study, it was felt that the most objective indications were change in range of motion, change in degree of tenderness to pressure, and change in extent of "hardness" of the muscles on palpation. If, after two weeks of carisoprodol* therapy, complete range of motion had been restored, there was no muscle tenderness, and if the muscle had its normal tone, the response was considered to be excellent. If range increased to almost normal, tenderness was slight, and tone moderately abnormal, the result was evaluated as good. If there was some improvement in each of these, but not enough to be considered a substantial improvement, the rating was fair. Poor responses were those in which there was little or no change in the patient's condition.

TABLE 1.

Cases	RESULTS Excellent	Good	Fair	Poor	Per Cent Good or Excellent
Acute					
10 Long bone fractures	9	1	0	0	100
10 Postoperative herniated discs	9	0	0	1	90
13 Other herniated discs	8	5	0	0	100
13 Lumbosacral strain	3	3	5	2	42
12 Osteo-arthritis	4	7	1	0	92
32 Cervical hyper-extension	23	5	2	2	87
18 Cervical osteo-arthritis	10	4	2	2	91
6 Calcific tendinitis	6	0	0	0	100
114 Acute Cases	72	25	10	7	85%
Chronic					
10 Periarticular capsulitis	7	3	0	0	100
3 Osteo-arthritis—hips	0	2	1	0	67
2 Osteo-arthritis—knees	0	1	1	0	50
5 Lumbosacral osteo-arthritis	0	4	1	0	80
2 Gout	0	0	0	2	0
22 Chronic cases	7	10	3	2	77
114 Acute cases	72	25	10	7	85
136 Grand Total	79 (58%)	35 (26%)	13 (9%)	9 (7%)	84 (84%)

RESULTS

As can be seen in Table 1, response to the carisoprodol* therapy was particularly gratifying in the group of patients with acute disabilities. Of the 114 patients in this group, 97 or 85 per cent, had excellent or good responses. They experienced complete or almost complete remission of severe pain, muscle spasm, and limitation of motion. Only seven patients failed to respond to the treatment.

Notable was the 100 per cent response of the ten patients with long bone fractures. These patients were placed in either Russell's traction or skeletal traction and were given 400 milligrams of carisoprodol* four times a day. Within 48 hours, the musculature had completely relaxed and the overriding of the fractures had been completely corrected, as proved by x-ray. Four of these fractures were of the femoral neck in elderly patients and the relief of their pain was remarkable.

Within the group suffering from cervical hyperextension, 23 or 72 per cent of the 32 showed complete relief of spasm within a week after carisoprodol* treatment was begun. Complete range of motion had been restored and pain had been markedly reduced.

Of the ten patients who were given carisoprodol* following surgery on herniated discs, nine had excellent responses. Palpation of the muscles showed that they had lost their hardness and that the spasm had disappeared. Similar responses were found in the 13 patients being treated for herniated discs (as proved by myelogram) without surgery. After one week of carisoprodol* therapy, eight of these patients had regained a complete range of motion, and had lost all muscle spasm and pain. The remaining five responded somewhat more slowly, but in no case was treatment required for longer than two weeks.

All six patients with acute calcific tendinitis regained full range of motion and had complete relief of pain. Palpation showed that the muscle had lost the hardness which normally follows spasm, and was no longer tender.

The 13 patients treated for an acute exacerbation of chronic lumbosacral strain responded somewhat less satisfactorily. In this group were patients with congenital changes, postmenopausal fibromyositis, and two cases of spondylolisthesis. Only three patients were considered to have had an excellent result from the treatment, and three were rated as good. Of the remaining seven patients, two developed reactions to the drug and it was discontinued after two days. Five of these seven patients had a severe emotional overlay in their symptoms. Although carisoprodol* is chemically related to the tranquilizer, meprobamate, it is pharmacologically different and did not improve the psychosomatic symptoms of these five patients.

Within the group of 22 patients suffering from chronic musculoskeletal disorders, 17 (or 77 per cent) had good or excellent responses. Perhaps the most startling responses were shown by patients with periarticular capsulitis or "frozen shoulder." The dramatic results in these ten patients were the relief of pain and the relief of the usual ligneous consistency in the muscles of the shoulder girdle. The improvement in the range of motion was not as startling as it might have been, but when the muscles were used for a month to six weeks the range of motion increased approximately 50 per cent. In addition to carisoprodol,* these patients received physical therapy. Despite the limitation of range motion, the responses of seven patients were rated as excellent and the other three as good.

Within the chronic group, also, patients with osteoarthritis of weight bearing joints responded less well than patients with other conditions. None of the ten patients in this group was considered to have had an excellent response. However, seven responses were rated as good because of increased range of motion and obliteration of spasm. In the lumbosacral disabilities, the acute discomfort and pain with the limitation of motion and marked hardness of the paraspinal muscles was to a great extent relieved. These responses might have been rated as excellent had there not been a residual soreness and slight aching rather than acute pain and discomfort.

Two patients whose symptoms of elevated uric acid and the presence of tophi resulted in a diagnosis of gouty diathesis received little relief from carisoprodol.* The analgesic response was similar to that obtained with aspirin.

SIDE EFFECTS

No severe, serious reaction to carisoprodol* was noted. Only seven patients had any side effects. Five of them reported fatigue and weakness, and two complained of vertigo with nausea or vomiting. These reactions occurred

even though dosage for these patients had been reduced to only one tablet a day. In spite of this, since 107 persons had no reaction to the drug, it can be assessed as having a very low toxicity. Three patients took the drug three times a day for over six months with no ill effect.

Laboratory tests on hospital patients revealed no disturbance of the blood count, nonprotein nitrogen, cephalin flocculation, or thymol turbidity. Furthermore, urine examination showed no evidence of renal damage.

DISCUSSION AND CONCLUSION

IN EVALUATING this drug, as with all drugs, the clinical benefits to be obtained must be weighed against the risks. Some might consider muscle relaxants were not indicated in orthopedic conditions, since muscular spasm with its associated pain is nature's way of splinting a painful skeletal injury. However, muscle spasm may be harmful in such conditions as fractures of the long bones and is certainly not beneficial to patients lying in bed after an operation. Similarly, pain may inhibit motion of a shoulder even when motion is indicated and pain certainly tires the patient. Spasm is not necessarily valuable and may be harmful.

Where there was spasm of traumatic origin, carisoprodol* proved of particular value. The overriding fractures were relieved by the drug, and the patients were better able to rest due to the relief of pain. The postoperative patients were similarly relieved of pain, and their relief from spasm was gratifying.

Patients with herniated discs who were treated without surgery also did well. If spasm were a necessary defense in such cases they would not have done so. Probably the laboratory finding that carisoprodol* relieved pain without interfering with defensive reflexes explains this.

Thus, it is concluded that carisoprodol* is a valuable agent for the relief of pain and undesired muscular spasm in orthopedic conditions, particularly those due to acute traumatic injuries and those associated with excessive reflex spasm such as is found in patients with cervical hyperextension, herniated disc, periarticular capsulitis and postoperative conditions.

*This is tradenamed by Wallace Laboratories of New Brunswick, N.J. as Soma®.

SUMMARY

CARISOPRODOL* (N-isopropyl-2-methyl-2-propyl-1,3-propanediol dicarbamate) a muscle relaxant with analgesic properties, was used to treat 136 orthopedic patients whose symptoms included pain and muscle spasm. The patients were evaluated clinically for the relief of pain, increased ranges of motion, and relief of muscle tenseness. Excellent or good responses were observed in 114 patients: a rate of 84 per cent. Only seven patients reported untoward effects; these were mild and not serious.

The drug was most effective in the treatment of acute musculoskeletal disorders such as long bone fractures, calcific tendinitis, cervical hyperextension as well as in the nonsurgical and postoperative care of herniated discs. Chronic cases of periarticular capsulitis also showed remarkable improvement. Longstanding chronic osteoarthritis, as would be expected, did not respond as well as other conditions.

Carisoprodol* is a valuable adjunct for the relief of pain and undesired muscular spasm in orthopedic conditions, particularly those due to acute trauma or with associated reflex spasm.

48 Plymouth Street

Abraham M. Balter, M.D.

Irving E. Blecher, M.D.

Lyons

Treatment of Pneumococcus Meningitis*

Pneumococcus meningitis is a dangerous disease that requires energetic treatment. The authors believe it injudicious to depend on a single drug, and here outline a rationale for multiple therapy.

The history of pneumococcus meningitis since the availability of chemotherapy and antibiotics, shows an interesting development from the time when its 100 per cent mortality was left in the past, to the present when there are many effective therapies. Over the years the rate of recovery has increased. The percentage of recovery has varied with different physicians at different times; and the evolution of treatment has been in the direction of increasing emphasis on only one antibiotic: penicillin.

After the introduction of the sulfonamides, the mortality rate fluctuated from 31 per cent to 80 per cent; but the rapidity of clinical response was markedly variable.[4] Permanent neurologic damage was not frequently reported in adults but was common and often severe in children.

When penicillin was introduced [10] and combined with sulfonamides, the results became more favorable. Cases in which the sulfonamides alone could only impede the progress of the disease but not cure it, now went on to complete recovery.

Intrathecal penicillin was soon introduced but the dosage that was combined with it was very small: 10,000 to 15,000 units every 3 hours with an initial loading dose of 50,000 to 75,000 units intravenously.

By 1946, penicillin was recommended in "enormous dosage"—1,600,000 units per day for two weeks with 25,000 to 30,000 units intrathecally twice daily for a week and once daily for another week. Sulfadiazine was given also. There was a lively debate on the necessity for intrathecal penicillin and it was generally abandoned, although it continued to have its proponents [3] as late as 1952. Studies were made on the penetrability of penicillin through the normal meninges as compared to the inflamed state.[2] The meninges were not penetrated easily in the normal state, but inflammation allowed a freer appearance of this antibiotic in the cerebrospinal fluid. However, the penetrability varied with different patients. There was also a difference in the disease as it affects infants, older children and adults.

There was a growing recognition that the dose of penicillin must be large. By 1947, five million units per day were recommended for the common meningitides. That the disease itself was very variable was demonstrated clearly in those patients who had repeated attacks of the disease.[5] At first the patient recovered with sulfonamides alone. Later, after repeated attacks, the sulfonamides were ineffective, but recovery would take place with addition of penicillin.

When penicillin was given intrathecally, it was not unusual to blame it for damage to the meninges or for subarachnoid effusion with

*From the Medical Service of the Veterans Administration Hospital, Lyons, N. J.

hemorrhage, although the pneumococcus is well known for its ability to cause these conditions. Infants appeared to be more readily damaged by the disease than adults.[7]

By 1949 a new phase in treatment of this disease was introduced with administration of 1,000,000 units of penicillin every 2 hours. With this dosage the use of sulfonamides appeared unnecessary.[1]

Chloramphenicol[9] was used in 1950. Because of ready penetration through the meningeal barrier, its value could be demonstrated repeatedly. By 1951 even larger dosage of penicillin was being used, as much as 24,000,000 units per day.

That pneumococcus meningitis could be treated successfully with antibiotics other than penicillin was demonstrated in 1957 when tetracycline was used for purulent meningitis.[6] This antibiotic appeared to be able to penetrate the meninges quite readily.

In 1958 ACTH and cortisone were added to heavy dosage of penicillin, the latter given in quantities as much as 60,000,000 units per day.[8] With this dosage, there is no way of estimating the relative merits of the hormones as compared to the penicillin. Thus the dosage of this antibiotic had risen from almost insignificant amounts to as much as 37.5 Grams per day.

CASE REPORTS

Our own experience with pneumococcus meningitis demonstrated that multiple therapy with various antibiotics and other medications has its advantages, and that large dosage of antibacterial drugs is a prime necessity.

CASE ONE

This patient had traumatic encephalopathy due to a gunshot wound of the head twenty months before the present illness. The bullet had entered the right temporal area in front of and above the ear, and travelled across the brain. Roentgenogram showed the bullet within the left parietal lobe. There was blindness of the left eye. The patient was on trial visit when he first became ill and was brought to the hospital in a restless and comatose state. Both pupils were dilated and there was slight bulging of the right eye with marked conjunctivitis. He showed nuchal rigidity with positive Kernig's and Brudzinski's signs. Spinal puncture yielded a cloudy fluid which contained 1800 leukocytes per cubic millimeter and many pneumococci. Pending the outcome of sensitivity tests, the patient was given 300,000 units of penicillin every six hours and sulfadiazine 5 Grams, both intravenously. Tests showed that the organism was very sensitive to chloramphenicol. It was resistant to penicillin, dihydrostreptomycin, streptomycin and slightly sensitive to oxytetracycline. The medication was accordingly changed to chloramphenicol one Gram every six hours for a total of 4 Grams per day. Sulfadiazine was continued at the rate of one Gram every four hours for a total of 6 Grams per day. The patient remained deeply comatose except for short intervals. He was fed a liquid diet through a Levin tube. The chloramphenicol and sulfadiazine were administered through the tube. During the time that the patient was on penicillin and sulfadiazine, his temperature rose from 101.8 to 103.8. After the chloramphenicol was initiated the temperature fell steadily, and after three days it was down to 100, and the patient began to regain consciousness. By the fifth day, he was able to take food and medication by mouth. A second spinal fluid on the seventh day, yielded 12,600 leukocytes, but the culture showed no growth. Six days later, the sulfadiazine was reduced to one Gram every six hours and discontinued altogether on the 19th day. The sulfadiazine was resumed on the 27th day because the temperature which had been varying between normal and 100 rose to 101 on the 25th day. It was finally stopped on the 39th day after the temperature had been normal for twelve days. The chloramphenicol was reduced to one Gram every eight hours, or 3 Grams per day on the 19th day and stopped altogether after 27 days of treatment on this drug. On this day the spinal fluid contained only 11 leukocytes and was still negative on culture. Clinically the patient improved steadily until the 39th day when he was sent home.

Two years later, he was readmitted to a psychiatric ward of this hospital. A month later he was transferred to the Medical Service because of a chill, nausea, vomiting, fever of 102, and stiffness of the neck with a positive Brudzinski's sign. In a few hours the temperature rose to 106 and the patient became comatose. The blood count was 64,000 leukocytes with 94 per cent neutrophils. Spinal fluid was cloudy with 7,000 leukocytes per cubic millimeter of which 98 per cent were neutrophils. Many gram positive diplococci could be seen. On culture these proved to be pneumococcus, Type 34. The organism was markedly sensitive to chlortetracycline, chloramphenicol, penicillin, erythromycin, tetracycline, oxytetracycline, sulfathiazole, sulfadiazine, sulfamerazine and Gantrisin.® It was moderately sensitive to streptomycin. The patient was started on chloramphenicol 4 Grams per day by mouth. As he soon became unconscious, he was given 100 milligrams of tetracycline in an

intravenous solution of glucose and saline. This was followed by another 500 milligrams of tetracycline intravenously. Because the organism was sensitive to penicillin and because of a fear of possible toxic effects of chloramphenicol, the medication was changed to 600,000 units of penicillin intramuscularly, and 1,000,000 units of soluble penicillin every two hours. Streptomycin, 0.5 Grams, was given twice daily. He was also given cortisone intramuscularly. The patient failed rapidly and died after two days of illness.

Autopsy showed yellowish-green purulent matter over the left parieto-occipital region and at the base of the brain in the region of the left optic nerve at its origin near the optic chiasm. There was purulent matter in the ethmoid sinus. Section of the brain after fixation showed exudate extending into the recesses of the sulci. Section of the left parietal and occipital areas revealed a bullet imbedded in the brain approximately 0.3 centimeters beneath the surface. It was surrounded by fibrous tissue, but no pus. The meningitis was evidently caused by the ethmoiditis and not by a purulent focus around the bullet. Although treatment was begun early during the second attack, it was not effective in spite of a dosage of 1,000,000 units of penicillin every 2 hours and concurrent medication with sulfadiazine, streptomycin and cortisone.

CASE TWO

This 49-year old patient, a physician on the staff of this hospital, had hay fever and chronic sinusitis for many years. He developed an upper respiratory infection superimposed on a severe episode of hay fever. He had increased sneezing, headache and fullness in the ears. The following day he developed an earache and for a brief period of time had unsteadiness with vertigo. The headache and earache became more severe in spite of medication with oxytetracycline. The dosage was small. The next night, he reported a yellowish exudate from his right ear which stained his pillow. On the next day, he was still ambulatory in spite of increasing headache over the frontal, occipital and maxillary areas. The earache was reduced but hearing was somewhat impaired on the affected side. On the evening of the third day, the severity of the headache increased and the patient was irritable and dull. Next morning, he was deeply stuporous. His temperature was over 106. There was marked stiffness of the neck with a positive Kernig's sign but no Brudzinski's sign. He had a purulent discharge from the right ear, and the external auditory meatus was deeply inflamed and edematous. Spinal puncture yielded very cloudy fluid which contained 94,000 leukocytes per cubic millimeter, 90 per cent of which were granulocytes. Pneumococci were seen in almost every field. Tests showed that this organism (obtained from spinal fluid) was markedly sensitive to tetracycline, chloramphenicol, penicillin, oxytetracycline, erythromycin, chlortetracycline and nitrofurantoin, but only slightly sensitive to sulfathiazole and sulfamerazine, and not at all to sulfadiazine or Gantrisin.® Tests on the pneumococcus obtained from the blood showed the same type of sensitivity to the antibiotics mentioned, but there was also marked sensitivity to various sulfonamides. Total protein was 278 milligrams per cent with a marked increase in globulin. The spinal fluid was under a pressure of 300 millimeters of water. He had a leukocytosis of 22,250 with 90 per cent neutrophils. Blood culture was positive for pneumococcus. The treatment was begun immediately with 500 milligrams of tetracycline every four hours intravenously for a total of 3 Grams per day, and one Gram of chloramphenicol intramuscularly four times daily. On the following day, the patient had undergone a remarkable change. His sensorium had cleared and his temperature had fallen to 99.6, almost 7 degrees. Blood pressure was down to 132/92. He took liquids and soft foods by mouth and was very cooperative.

A second spinal puncture, done on this day, showed a pressure of 200 millimeters of water. The spinal fluid was still cloudy and contained 51,000 leukocytes of which 70 per cent were neutrophils. Total protein was 300 milligrams per cent. No organisms could be seen on direct examination of the fluid which was also negative on culture. The patient complained of severe headache. Chloramphenicol was continued at 4 Grams per day but the tetracycline was now given in the same dosage, 3 Grams per day by mouth. On the third day, the stiffness of his neck was considerably reduced and the patient could move his head from side to side and up and down. Many leukocytes were found in the urine. The patient was then given nitrofurantoin, 100 milligrams four times daily. This was continued for five days.

After the initial fall of more than six degrees, the temperature varied between 99 and 103 for the first three days with a general tendency to fall. Thereafter, his temperature remained normal until discharge. He improved steadily but continued to complain of pain behind his eyeballs. The deafness of his right ear improved steadily during convalescence until the hearing was restored. The blood count fell to 10,400 by the 16th day. The urine, which at first contained a trace of albumin and many leukocytes, rapidly cleared so that it was normal after a week. Spinal tap on the 13th hospital day, yielded clear fluid that contained 5 leukocytes and a total protein of 84 milligrams per cent. Roentgenograms of the skull showed slight increase in density of the mastoid cells and of the petrous pyramid on the right side indicating that at some time in the past this had been the site of an inflammatory process with resulting sclerotic change.

The chloramphenicol was reduced to 3 Grams per day on the second day and continued in this dosage until the twelfth day when it was lowered to 2 Grams per day. The tetracycline, on the same day, was reduced to 2 Grams per day. Nitrofurantoin was resumed at the rate of 400 milligrams per day on the 17th day and was continued for six days. The chloramphenicol was discontinued on the

fifteenth day. The tetracycline was reduced to 1½ Grams per day on the nineteenth day, and was discontinued on the twenty-second day. All the chloramphenicol that was administered to the patient was given parenterally. The patient was discharged fully recovered after 23 days of hospitalization.

CASE THREE

This patient was under treatment on a psychiatric ward until he developed vomiting and a temperature of 101.2. He was then transferred to the Medical Service. Urinalysis showed a trace of albumin, rare granular casts, and a few red blood cells. The patient complained of pain in the right lumbar area. The following day urinalysis showed 4-plus albumin with many bacteria and an occasional red blood cell. Because of an indefinite history of an old genito-urinary infection, it was believed that there was a recurrence of this infection and he was treated with tetracycline 100 milligrams twice daily intramuscularly, and penicillin 300,000 units twice a day. Nitrofurantoin 100 milligrams four times daily was given by mouth. Repeated physical examinations failed to reveal evidence of meningitis.

On the afternoon of the second day the patient developed a herpes involving the upper lip. Blood count showed a leukocytosis of 26,000. He was still receiving tetracycline 100 milligrams and penicillin 300,000 units, both intramuscularly. The nitrofurantoin was stopped because he was unable to retain it. Erythromycin was added 100 milligrams parenterally four times daily. By the 3rd day, he developed a temperature of 105.6, pulse 120, respirations 30. There was no Kernig's sign, but the patient was resistive, tense, restless and somnolent. The following morning, on the fourth day, temperature was 101 and he was much less restless and was considerably clearer mentally. Because of marked nuchal rigidity, a spinal tap was done. This yielded cloudy fluid which contained 3,500 cells per cubic millimeter of which 80 per cent were granulocytes. Culture of the spinal fluid showed pneumococcus, Type II. This organism was found, by test, to be markedly sensitive to chloramphenicol, penicillin, oxytetracycline, erythromycin, tetracycline, Ristocetin®, nitrofurantoin, and a number of sulfonamides. Immediately after the spinal tap, the patient was given 0.5 Grams of chloramphenicol intravenously in 250 cubic centimeters of water. He was also given 250 milligrams of tetracycline intramuscularly four times daily. On the fifth day, this was increased to chloramphenicol 500 milligrams and tetracycline 500 milligrams every 4 hours or six times in 24 hours for a total of 3 Grams each per day. Nitrofurantoin 100 milligrams was also given four times daily. By this time the patient, though no longer somnolent, was quite lethargic. He took fluids well. On the sixteenth day, the chloramphenicol was increased to one Gram intramuscularly every 6 hours for a total of 4 Grams per day. The nitrofurantoin was continued at 400 milligrams per day. The chloramphenicol was increased because of a persistent fever of 102. At this time, he could not close his right eye. He had anisocoria. His right pupil was markedly contracted; he had paralysis of the right side of his face, absent abdominal reflexes, a right positive Oppenheim sign with bilateral exaggerated patellar reflexes and a left ankle clonus. It was believed that the patient might have had a localization of purulent material and that operation would be necessary. He was transferred to the Neurologic Service. Medication was continued except that tetracycline was given intramuscularly in 100 Gram doses every 3 hours. Then this was raised to 500 milligrams every 4 hours or 3 Grams daily. Penicillin was given intramuscularly every 12 hours in dosage of 600,000 units. A second spinal tap on the day of transfer yielded clear spinal fluid which contained 682 leukocytes of which 80 per cent were granulocytes. Culture was negative.

On the seventh day there was distinct improvement in the neurologic symptoms. The patient was more alert. Spinal fluid examination on that day showed 241 leukocytes. The rigidity of the neck was diminished and the right facial paralysis was reduced. His speech was variable. In the light of subsequent developments, it appeared that this was due to his meningitis rather than to his psychosis. Two days later, he developed paresis of the right lower extremity with paralysis at the level of the toes and ankle. His general condition still appeared improved, with a temperature varying from 98 to 100. Later, another spinal tap yielded clear fluid but the cell count still showed 250 leukocytes. The patient improved steadily and the neurologic signs became progressively less marked. On the eighth day the tetracycline (which had been given parenterally) was now administered by mouth, 500 milligrams every 4 hours, making a total of 3 Grams per day. The other medications were continued as stated. On the thirteenth day the chloramphenicol was stopped and on the seventeenth day the tetracycline was discontinued. The penicillin and nitrofurantoin were continued until the twenty-seventh day when they also were stopped. The neurologic signs continued to recede, but a very slight, inconstant ankle clonus remained.

Recovery took place although the meningitis was not treated intensively for almost three days. During this preliminary period the patient was repeatedly examined but no evidence of meningitis was found. It is fortunate, however, that he received tetracycline, penicillin and some nitrofurantoin and erythromycin in ordinary dosage from the beginning of his illness. He received 3 Grams of tetracycline for one day which was then reduced to 100 milligrams intramuscularly every three hours for a total of 800 milligrams daily for six days, after which it was given in 500 milligram dosage by mouth six times daily for a total of 3 Grams per day for seven days. The chloramphenicol was given in a dosage of 4 Grams daily for 14 days. Penicillin 1,200,000 units and nitrofuran-

toin 400 milligrams per day were given for twenty-seven days. The medications were continued for the period of time indicated because of the development of neurologic symptoms which at first seemed to indicate the possibility of an abscess. The subtle beginning of the disease in which there was at first no clinical evidence of meningitis gave the infection a start which was held in check only to a poor degree because of low dosage of the medications.

COMMENT

PNEUMOCOCCUS meningitis is a dramatically swift and devastating disease that calls for prompt and energetic treatment. The factors involved between the infection and the reaction of the host can be freakishly variable. The organism exists in many types and many degrees of virulence. The range of resistance of the host is very great, but its status cannot be determined at the time the patient is first seen, and the duration of the disease and the extent of the damage it may already have caused, may well be a matter for speculation. The presence of a primary focus of infection must be assumed but may be impossible to find, and skull injury is a probability that must always be investigated. An added uncertainty is that the diplococcus pneumoniae may not always be found either on smear or culture of the spinal fluid even though there is every evidence otherwise of a pyogenic infection of the meninges. Even when the culture of the organism shows the presence of the pneumococcus, sensitivity tests with the various sulfonamides and antibiotics are not always accurate and dependable.

When the meninges are inflamed, antibiotics penetrate the blood-brain barrier quite readily; but they do so in variable concentrations in different patients. Administration of any one antibiotic, even in high dosage, does not necessarily mean that an effective level will appear in the spinal fluid; neither does it mean that the invading pneumococcus will be sensitive to it even if the level in the spinal fluid is high. The remarkable cases that have been reported as phenomenal recoveries indicate their unusual nature rather than the ease with which pneumococcal meningitis may be treated. A report of the individual cases that have been brought to the hospital only to die in spite of energetic treatment, would give a clearer idea of the broad requirements for the treatment of this disease.

One must assume that for each patient there is a critical point beyond which there will be permanent brain damage if the infection is not treated soon enough or adequately enough; and another point beyond which recovery will not take place at all. Because there is no way to determine the status of the patient in this regard, treatment must be based on the assumption that the point of danger has not yet been reached but is perilously near. The period of greatest uncertainty (which is most critical for the patient) is during the first 24 hours when all the variables and unknowns present their combined challenge.

To depend on one drug alone is to confine the treatment unnecessarily when the disease itself may be of unconfined variability and severity. The steady increase over the years in the size of the dosage of penicillin speaks for itself. If 60,000,000 units (37.5 Grams) may be given in one day, then there is reason for using more than one antibiotic;[8] and for that matter, for applying a regimen of multiple therapy for a disease that has multiple and dangerously immediate possibilities. There is a legitimate objection to multiple therapy when it is used to spray the field for unknown diagnostic possibilities, but it is a different matter when the diagnosis is already established as pneumococcus meningitis or at least as a purulent meningitis, and treatment is necessary for a variety of unknown but deadly potentialities.

CONCLUSION

PNEUMOCOCCUS meningitis is a highly variable disease for which multiple therapy is recommended. Chloramphenicol in dosage of 3 to 4 Grams per day, tetracycline 3 to 4 Grams per day, both intravenously, should be administered for the first two or three days or for a shorter time if improvement is sufficiently prompt. Intramuscular, then oral medication would be substituted as soon as feasible, and should be continued in gradually diminishing dosage for two weeks after the temperature

has fallen to normal. This regimen may be freely varied to meet the requirements of the individual case.

This is not to say that the medications would be completely successful with every patient; but even if they were not entirely effective, they would be more dependable as a group than any one preparation in carrying the patient along until sensitivity tests would indicate the proper medication with some degree of certainty. Whatever the medicaments that prove to be the most desirable, more than one should be given and the dosage should be very large. The sulfonamides, nitrofurantoin, anti-inflammatory corticoids and such preparations as injectable streptokinase-streptodornase and intramuscular trypsin should also have a place in the treatment of this disease.

BIBLIOGRAPHY

1. Dowling, H. F., Sweet, L. K., Robinson, J. A., Zellers, W. W. and Hirsh, H. L.: Am. J. Med. Sci., 217:149 (1949).

2. Dumoff-Stanley, S., Dowling, H. F. and Sweet, L. K.: J. Clin. Invest. 25:87 (1946).

3. Gibson, D. and James, D. G.: The Lancet, 2:1203 (1952).

4. Hodes, H. L., Smith, M. H. and Ickes, H. J.: J.A.M.A., 121:1334 (1943).

5. Hoyne, A. L. and Schultz, A.: Am. J. Med. Sci., 214:673 (1947).

6. Koch, R. and Hansen, H.: J. of Ped., 51:65 (1957).

7. Lowrey, G. H. and Quilligan, J. J.: J. Pediat., 33:336 (1948).

8. Ribble, J. C. and Braude, A. I.: Am. J. Med., 24:68 (1958).

9. Riley, H. D.: J. of Ped., 37:909 (1950).

10. Waring, A. J. and Smith, M. H.: J.A.M.A., 126:418 (1944).

The Veterans Administration Hospital

Doctors' Smoking Habits

A marked change has occurred in the smoking habits of Massachusetts physicians during the past five years, according to surveys conducted in 1954 and 1959 among approximately 5,000 physicians.

In 1959 only 39 per cent reported smoking cigarettes as contrasted to 52 per cent in 1954. About half the current cigarette smokers use less than 1 package per day. "The decline in cigarette smoking is spectacular among those who smoke 1 package daily or more. In this group, the rate changed from 30.5 to 18.0," the authors said.

"These data indicate a growing awareness among the medical profession of the 'potential danger of smoking cigarettes as an avenue which may lead to lung cancer.'"

—Snegireff, L. S. and Lombard, O. M.: *New England Journal of Medicine,* 261:603 (Sept.) 1959.

Drinking *vs.* Driving

Driving performance begins to deteriorate with quite low blood alcohol concentrations, according to a recent report in the *British Medical Journal.* Volunteers were tested on a motor-driving trainer before and after four test doses of alcohol. Age, sex, previous driving experience and previous drinking habits showed no relation to individual differences in response to alcohol. Personality traits, on the other hand, showed a definite relationship. Extroverts became less consistent in control movements and showed large increases in error. Introverts changed speed considerably but it was not possible to differentiate those who slowed down and those who speeded up. Their mean error score, however, was significantly less than for extroverts.

By the London Post, *New England Journal of Medicine,* Sept. 24, 1959.

HERMAN H. TILLIS, M.D.

Newark

Prednisolone-Hydroxyzine Treatment of Rheumatoid Arthritis*

In treating arthritis with corticoids, there is always the problem of side effects when adequate dosage is administered. This study from the United Hospitals of Newark suggests that by adding hydroxyzine to the medication, side effects can be eliminated, the effective dose of the steroid can be reduced, and concomitant emotional tension can be minimized.

ADMINISTRATION of glucocorticoids to patients with rheumatoid arthritis can produce a wide array of undesirable metabolic effects; such as sodium retention and edema hypertension. These effects can be minimized by reducing dosage, when feasible, or by combining minimal doses of the steroids with other anti-inflammatory agents such as the salicylates. It is also possible to give specific medication to counteract untoward effects of the steroids.

The course of rheumatoid arthritis is significantly affected by anxiety or other emotional stress [1,2,3,4,5] and the frequency and severity of recurrent episodes are often related to such factors. It is therefore rational to prescribe a tranquilizer in addition to steroid medication. When tension is relieved by an ataractic agent, less steroid is required; and undesirable side effects are less frequent and less severe. There is the added advantage that the tranquilizer counteracts the stimulatory action of steroids, generally undesirable in patients with rheumatoid arthritis.

In a previous paper, I reported on the use of prednisolone and hydroxyzine in rheumatoid arthritis.[5] All patients were benefited by the combined medication, which made it possible to reduce dosage of prednisolone and to decrease the incidence of side effects. Warter [6] reported similar results, and found that in some cases toxic reactions to the steroid subsided when the tranquilizer was added.

MATERIALS AND METHODS

IN THE present investigation prednisolone† was used in conjuction with a new salt of hydroxyzine, hydroxyzine pamoate,‡ which is said to have longer action than the hydrochloride. Salicylates were also prescribed for most of the patients in order to keep steroid dosage low. The group consisted of 24 women and 8 men aged 27 to 73 years; 31 of the patients had rheumatoid arthritis and 1 rheuma-

*From the Arthritis Clinic, United Hospitals of Newark, Presbyterian Unit, Newark, New Jersey.

†Supplied by Pfizer Laboratories as Sterane® Tablets.

‡Supplied by Pfizer Laboratories as Vistaril® Capsules.

1. Johnson, A., *et al.*: Rheumatic Disease. St. Louis, 1952. Mosby: page 77.

2. Ludwig, A. G.: M. Clin. North America, 39:447 (1955).

3. Boland, E. W.: Psychogenic Factors in Rheumatic Diseases in Comroe's Arthritis. Philadelphia, 1953. Lea and Febiger: page 497.

4. Dresner, E.: Am. J. Med., 18:74 (1955).

5. Tillis, H. H.: Am. Pract., 8:932 (1957).

6. Warter, P. J.: J. M. Soc. New Jersey, 54:7 (1957).

toid spondylitis. Six of the arthritic patients were in Stage I; 11 in Stage II; 12 in Stage III; and 2 in Stage IV. All had emotional involvement of some degree. Duration of the arthritis ranged from 1 to 17 years, with an average of 7½ years. Five had latent peptic ulcers and an additional 14 suffered from other conditions.

Each patient had a meticulous physical examination and laboratory work-up, including urine analysis, blood serology, differential blood count, erythrocyte sedimentation rate, blood sugar and uric acid and chest fluoroscopy. X-ray and other studies were done when indicated.

The initial oral dose of prednisolone† ranged from 10 to 30 milligrams a day, given in three parts, the largest dose in the morning. At the end of a week, dosage was reduced by 2.5 milligram decrements at intervals of one to two weeks until the smallest effective dose was reached. The objective was to maintain comfort and relieve pain, and at the same time to minimize Cushingoid manifestations. Dosage was lowered to 2.5 milligrams two or three times daily in 22 cases, to 10 milligrams per day in 8, and 3 patients required 12.5 to 20 milligrams. Prednisolone was continued for at least a year.

The initial dose of hydroxyzine pamoate‡ was 25 milligrams three times daily. This dosage was varied according to the response of the patient. In addition, 31 patients were given salicylates, usually 10 grains every 4 hours. Six patients had intra-articular injections of hydrocortisone,§ 25 milligrams, when necessary to relieve joint pain. Other medication, including diuretics, iron, gold, ascorbic acid, codeine, estrogens and antacids were given as occasion demanded.

The response to prednisolone† and hydroxyzine‡ was classified according to the degree of comfort and calm maintained and according to the size of the dose of prednisolone required. An *excellent* response was comfort of more than 70 per cent on dosage of 5 to 7.5 milligrams of prednisolone,† a minimum of steroid side effects, and calming effect sufficient to overcome anxiety, tension or stimulation due to steroid therapy. A *good* response was the same as excellent, but with not more than 70 per cent patient comfort. A *fair* response was the same as good, but with prednisolone dosage at 7.5 to 10 milligrams daily. A *poor* response was less than 70 per cent comfort or 10 to 20 milligrams of prednisolone, or inadequate calming effect.

§Supplied by Pfizer Laboratories as Cortril®.

RESULTS

All but 4 of the patients derived significant benefit from the treatment, and the response was judged as excellent or good in 23 of the group (70 per cent).

Excellent response including 1 with spondylitis	11	(33%)
Good response including 1 with scleroderma	12	(36%)
Fair response	6	(18%)
Poor response	4	(12%)

The addition of hydroxyzine‡ to prednisolone† was of definite value. Nervous excitation, so common in steroid therapy, was virtually nonexistent in this group. Hydroxyzine‡ also appeared to alleviate gastro-intestinal symptoms in the five patients with peptic ulcer and in a sixth who had complained of severe gastric distress. This particular effect was probably achieved because of the other beneficial action of hydroxyzine‡ in such patients; its power of reducing gastric acidity.

Side effects from prednisolone† were mild and for the most part self-limited. There was no salt retention, potassium loss, edema, or hypertension, and no evidence of osteoporosis. However, "moon face" developed in a few of the patients. Two patients had mild episodes of ecchymosis, which seemed to respond to large doses of ascorbic acid. Appetite was usually stimulated and weight gain was common. The only side effect traceable to hydroxyzine‡ was mild drowsiness in a few patients at the start of treatment; this subsided while treatment was continued.

Three patients, one of whom was a diabetic, died of acute coronary occlusion during the study. In no case could death be attributed to either of the medications.

1. A widow of 59 had arthritis of 10 years' duration involving the hands, knees and feet. It was diagnosed as Stage III, Class III. As she had to work for her living, it was of paramount importance to relieve the crippling discomfort. She had been treated for a peptic ulcer induced by prolonged administration of cortisone and hydrocortisone. Treatment was begun with 20 milligrams of prednisolone† and 75 milligrams of hydroxyzine‡ daily. The prednisolone† gradually reduced to 10 milligrams daily. Discomfort due to marked changes in her knees was relieved by occasional intra-articular injections of hydrocortisone. Overall results of treatment were very good. She reported satisfactory relief of joint pain and gastro-intestinal discomfort, and improvement in mood and well-being. Treatment is being continued without noticeable side effects.

2. A mechanic aged 64, had had a sudden onset of Stage I, Class I rheumatoid arthritis of the hands, knees and feet one year prior to treatment. The condition was almost crippling enough to prevent him from working at his trade, on which he depended for his livelihood. He was given 10 milligrams of prednisolone† and 50 milligrams of hydroxyzine‡ daily at the start of treatment. His response was so dramatic that dosage was reduced to 5 milligrams prednisolone† and 25 milligrams of hydroxyzine‡ within two weeks. Several weeks later all medication was stopped, but the condition recurred and maintenance therapy was resumed. He is now symptom-free and working full time.

3. A woman of 42 had a 12-year history of rheumatoid arthritis, Stage II, Class II. She had been treated for 8 years with gold in conjunction with cortisone, hydrocortisone, prednisolone,† or salicylates. On the regimen she was maintained in comfort of 70 per cent, but with considerable irritability. Initial dosage was 15 milligrams of prednisolone† and 75 milligrams of hydroxyzine,‡ subsequently reduced to 7.5 milligrams of prednisolone† and 50 milligrams of hydroxyzine.‡ The patient reports that she has less pain than during the previous treatment, although there is no objective change in joint mobility. Her entire outlook has improved, she appears calm, and she tolerates the medication well.

Results of treatment with prednisolone† and hydroxyzine,‡ with or without other medication, should be considered outstanding in view of the fact that 27 of the 31 patients with rheumatoid arthritis (87 per cent) had 70 per cent relief of pain and increase in comfort, with minimal side effects and significant improvement in well-being. The absence of serious side effects was ascribable to the low dosage of prednisolone,† which was made possible by the addition of hydroxyzine.‡ Dosage of any corticoid necessary to effect comparable relief and comfort would precipitate salt retention edema, and hypertension in over half the patients. These effects were not seen in the present series of cases. Hydroxyzine‡ by allaying the emotional component of the disease, contributed to the relief of pain by relaxing tension, and improving mood and outlook. Furthermore, hydroxyzine‡ counteracted the undesirable stimulation of prednisolone,† so that the patients were able to relax and to sleep well. In my opinion there is no better treatment available for rheumatoid arthritis, especially when it is aggravated by emotional factors, as it nearly always is. Because of the minimal incidence of side effects, treatment can be continued over long periods, creating a reasonably active and happy life for patients who would otherwise be virtually incapacitated by crippling pain.

SUMMARY AND CONCLUSIONS

THIRTY-ONE patients with rheumatoid arthritis, and one with rheumatoid spondylitis were treated for a year or more with a combination of prednisolone† and hydroxyzine.‡ The maintenance dose of prednisolone† was 5 to 7.5 milligrams in 23 cases, and 7.5 to 10 milligrams daily in 6. Dosage of hydroxyzine‡ was usually 50 to 75 milligrams daily. The degree of pain relief and increased comfort was estimated at 70 per cent in 27 of the 31 patients with arthritis (87 per cent), and in 29 of the entire group (90 per cent). The only side effect caused by prednisolone† was "moon face" of relatively minor degree in some patients. Hydroxyzine‡ caused minor drowsiness in a few cases but was otherwise perfectly tolerated.

Hydroxyzine‡ was considered to be a useful adjuvant to prednisolone† for three reasons. It allayed the emotional component of arthritis, bringing about relaxation and improvement of mood. Second, because of hydroxyzine's‡ ability to depress and secretion in the stomach, it became possible to treat with confidence six arthritic patients who also suffered from gastric complaints such as ulcer and gastritis. All six patients found improvement not only in their arthritic joints but also

in their abdominal symptoms. Perhaps the most valuable result of combining prednisolone with hydroxyzine‡ was that it allowed the maintenance dose of the steroid to be reduced to very small amounts. Thus, steroid side effects were virtually avoided in treatments extending over prolonged periods of time.

31 Lincoln Park

Father Can't Win

Janine Noel (no father herself) says that lack of firm guidance by the father can cause trouble. Writing in the Parisian pediatric Journal, *Medicine infantile* (66:17, January, 1960) Dr. Noel says that in many families children are allowed to develop along the lines of their own nature; often this results in the children becoming unmanageable; or they develop personality disturbances. In other families the children are protected against the realities of the world, so that they never learn to behave in difficult circumstances or to make an independent choice. Those children too may develop emotional disorders.

It is often thought that it is the mother's task to guide the child's development. This is a mistake. It is the father who must awaken feelings of security in the child, and guide the relations developing between him and the outside world. The father has to promote the infant's aggressiveness, or dynamism, and should be the object of competition and identification.

Lack of firm guidance from the father may lead to psychoneuroses, asthma and enuresis. When the father knows how to interpret his children's needs, even severe emotional disturbances may disappear.

The father is the link between the fireside (the security that he guarantees) and the outer world, which he helps the child to decipher and to face. He should mobilize all the potentialities of his own character and personality to assist the mother in forming the child's character. It is better for the father to be too strict than too weak. The father's virility will largely determine the child's future attitude to the world.

Yawning as Exercise

Writing in the *Schweizerische Medizinische Wochenschrift* for December 1959 (89:1356) A. L. Vischer points out that yawning is a highly complex act. It occurs after awakening, even when the sleep has been refreshing. It occurs during fatigue. It may signal hunger. It may result from apoplexy, epilepsy and cerebellar lesions, anemia, cachexia, and vascular disorders. Psychic conditions producing yawning include sleepiness, fatigue, weariness, great expectations, hysteria and psychopathic states. Suggestion and involuntary imitation may also bring it on.

Yawning bears some relation to sighing, laughing, crying and coughing. It is almost always accompanied by involuntary stretching movements of all parts of the body. As a result the muscle tone is generally increased. The primary purpose of yawning is to bring the body into a state of activity. Newer observations on patients with brain-stem lesions suggest that a yawning center is located in the substantia reticularis of the myelencephalon.

When patients with one-sided paralysis yawn they often show spontaneous contractions of muscles which are otherwise completely paralyzed. There is usually a slow flexion of the elbow, wrist and fingers, with the fingers widely spread. The movements are probably reflex.

Attempts have been made to employ these spontaneous movements as a means of giving paralyzed patients exercise, in the hope that this would lead to a renewal of voluntary control over the paralyzed muscles. Up to now these attempts have failed largely because no ready means of stimulating repeated yawning has yet been found.

Samuel Fisher, M.D.

Frederick E. Lee, M.D.

Dorothy Supliki, R.N.

Paterson

Griseofulvin Therapy for Tinea Capitis

In a Board of Health Clinic

If subsequent studies bear out these results, tinea capitis need no longer be a school health problem. In this series of 68 cases, griseofulvin was effective in 100 per cent.

This is a report on the treatment of tinea capitis in the pre-school and school age children at the Paterson Board of Health Clinic. The drug used was griseofulvin, an antibiotic derived from penicillium. This drug, first isolated by Oxford *et al.*,[1] is now proving to be the sheet anchor of therapy especially for tinea capitis due to Microsporum audouini. Blank and Roth [2] demonstrated its effectiveness with a large group of patients. Since then, many [3 4] have corroborated the effectiveness of griseofulvin in the treatment of tinea capitis.

Since 1955, the Paterson Board of Health has undertaken the treatment of tinea capitis at the request of the Board of Education. Until June 1959 the therapy consisted of the usual locally applied medicaments, manual epilation, clipping of the hairs and the wearing of cotton caps. It took eighteen months and more to obtain a cure. During June 1959 we obtained griseofulvin and have found it an amazingly simplified method for the treatment of tinea capitis.

Seventy-five patients with tinea capitis were treated with griseofulvin in this study. Of this group, 68 patients (ranging in age from 13 months to 13 years) completed the course and were cured. Seven patients were lost for various reasons.

All patients were observed on a weekly basis. To verify our clinical diagnosis, patients were examined under a Wood's filter light. A potassium hydroxide slide was prepared and a culture performed. All were positive for Microsporum audouini. Blood counts and urine analyses were done on the first visit and every two weeks thereafter. Blood counts and urine analyses were all normal except for one two plus albumin. This child had just recovered from scarlet fever and despite the fact that griseofulvin was administered, the urine was normal in two weeks. There were no bone marrow depression effects noted in the blood counts. Duration of infection of these children was from one week to three years.

Griseofulvin is prepared in 250 milligram tablets for oral administration.

Griseofulvin was administered according to the weight of the patient; up to fifty pounds,

1. Oxford, A. E., Raestrich, H. and Simonet, P.: Biochemical Journal, 33:240 (1938).
2. Blank, H. and Roth, F. J.: Archives of Dermatology, 79:259 (1959).
3. Kirk, Jacquelin and Ajello, Libero: Archives of Dermatology, 80:259 (1960).
4. Reiss, F.: "Treatment of Fungus Infections with Griseofulvin," presented to the Barnert Memorial Hospital Staff on Nov. 3, 1959.

500 milligrams daily; fifty to seventy-five pounds, 750 milligrams daily; and over seventy-five pounds, one Gram daily. Patients were instructed to shampoo the scalp every other day with soap and water and to clip the hair short weekly. Time required for a cure was from one to ten weeks, the average being four to five weeks. Patients were considered cured after having been observed at weekly intervals for three weeks and having been negative to Wood's filter light examination for this period.

Untoward reactions were noted in only two cases. One was a pityriasis rosea type reaction in which griseofulvin was continued until the patient was cured of the tinea capitis without further disturbance. The second child had urticaria during the fourth week of therapy. In this case, griseofulvin was discontinued at the end of the fourth week and an ointment was substituted. One week later his Wood's filter examination was negative as were the next two weekly examinations. He was discharged as cured.

We now note a marked reduction in the number of new cases referred by the Board of Education. This is attributed to the short time required to effect a cure thereby reducing the possibility of infection to others. We believe that tinea capitis will no longer be a major problem in our schools.

SUMMARY AND CONCLUSION

1. Sixty-eight pre-school and school age children were treated for tinea capitis due to Microsporum audouini with griseofulvin. In all cases, we required three negative Wood's filter examinations at weekly intervals after therapy was discontinued. These cases were then considered cured.
2. Cures were effected in from one to ten weeks after griseofulvin therapy was instituted. Average time was four to five weeks.
3. There was little evidence of toxicity to griseofulvin in these patients.
4. Griseofulvin is prepared in 250 milligram tablets and is administered orally.

ACKNOWLEDGMENTS

The clinical studies were done on patients at the Paterson Board of Health Clinic. The laboratory work, including the initial and follow-up blood counts and urine analyses were accomplished under the direction of the Laboratory Director, Miss Evelyn Brown.

The griseofulvin in this study was supplied under the tradename of Fulvicin® by G. Kenneth Hawkins, M.D., of Schering Corp., Bloomfield, N. J.

808 Madison Avenue

Epilepsy Leaflet Available

If you have a child patient suffering from epilepsy, advise the parents that they can get, without charge, the enlightening brochure, "You, Your Child and Epilepsy." This is published by the Federal Epilepsy Foundation. The pamphlet was written by John Nardini, M.D. and Genevieve O'Leary. Dr. Nardini is chief of neurology in the office of The Surgeon General of the Navy. Miss O'Leary is chief of social work at the Children's Center of the Catholic University of America.

To obtain a single free copy, the parent writes to the Federal Epilepsy Foundation, 1729 F Street, n.w., Washington 6, D.C.

Isolation Unnecessary in Thrush

City health regulations usually require the removal from the regular hospital nursery of any newborn with thrush. Kozinn and his colleagues from the Maimonides Hospital,* assert that this isolation is unnecessary. In the first place, many infants harbor the *Candida albicans* in the intestines for days, but are not suspected because the oral cavities are clear. Their study showed that, in any event, isolation had no effect on the prevalence or spread of thrush.

*Kozinn, P. J., *et al.* July 4, 1949, Journal of the American Medical Association.

Historical Article • • •

C. Malcolm B. Gilman, M.D.

Red Bank

Military Surgery in the American Revolution*

War has always been a period during which medical knowledge rapidly expanded and the American Revolution was no exception. The author of this article is a lineal descendant of the American Revolutionary surgeon, Major Charles Gilman.

Those of us who were subjected to the course in military medicine in medical school, will recall that most of the knowledge of the period 1770 to 1800 centered about one Ambrose Paré, Barber Surgeon to Napoleon. Leeching, cupping, puncture of laudable pus, bandaging of wounds and amputation constituted the usual range of surgery from the Crusades to the close of the eighteenth century. At least this was true on the continent. Barbers were committed to the profession of surgery and the best barbers became the surgeons. During the middle ages, medicine was practiced by the Church and this continued into American Colonial medicine.

In 1928, I was on the staff of the first curator of the new Army Medical Museum at Carlisle, Pennsylvania. This is the Army Field Medical School. Frequently we visited the Army Medical Musuem in Washington. There we found that practically all medical material started with the Civil War. Of course, there was the lonely original treatise by Colonel Beaumont, frontier surgeon, describing his work on the celebrated patient, Alexis St. Martin. St. Martin received a gun shot charge into the abdomen, which ultimately left a gastric fistula. Dr. Beaumont thereafter did pioneer work on gastric digestion. But, what actually was the surgery of the late eighteenth century in this country? How does one obtain this material?

American colonial surgery was intimately and intrinsically bound to the surgery of England and more particularly, to Edinburgh University in Scotland. The best surgeons in this country were educated in Scotland and included many outstanding practitioners. Benjamin Rush and William Shippen of Philadelphia, and Randolph of New Jersey, were educated at Edinburgh. Philadelphia was the mecca of American surgery and so remained for 100 years.

Doctors Joseph Warren, Benjamin Church, and William Boylston were the leaders in Boston medicine. The last picture in the minds of the survivors of Bunker Hill [1] was Dr. Joseph Warren, firmly planted on a mound of earth, swinging a gun barrel—the remains of a musket—and attempting to hold off the onslaught. This has been preserved in a beautiful oil by Evart Duyckinck. Later, Church was discredited, stigmatized as a traitor, and while fleeing to the West Indies, lost his life at sea.

In 1767, the following established King's College School of Medicine, later Columbia: Samuel Bard, Edinburgh, became Professor of Theory and Practice of Physic; Samuel Clos-

*Read February 17, 1960 before the New Jersey Medicine Club, at its meeting in East Orange, N. J.

sey, Trinity College, Dublin, became Professor of Anatomy; Dr. Peter Middleton, a Scotsman with an honorary M.D., became Professor of Pathology and Physiology; Dr. James Smith of Leyden, Chemistry; Dr. R. John V. B. Tennent, Edinburgh, Midwifery.

New York Hospital was established in 1775. The first President of The Medical Society of New Jersey was Robert McKean of Perth Amboy. Other leaders in American medicine were Dr. Alexander Hamilton of Annapolis, Maryland; Drs. John Morgan, Benjamin Rush, and Willam Shippen, Jr., of Philadelphia; Drs. John Cochran and James Craik of Virginia; Dr. David Oliphant of South Carolina. Dr. Shippen's daughter, Peggy Shippen, married Benedict Arnold, and Dr. Shippen's patriotism has often been questioned. The greatest achievements of the eighteenth century were cinchona for malaria and other fevers, and vaccination against small pox.

All medicine and surgery in this country before this time was practiced by ministers, barbers, or self-ordained irregulars. This group of leaders was trying to set up a worthwhile standard for practice. Dr. William Witherspoon of Princeton, then Nassau College, a minister, was also a practitioner, but with no M.D. Captain John Smith had no degree of any kind, but was a physician on the *Mayflower;* Fuller was the other. Boston, New York, Richmond, and Charlestown had their share of good men. Harvard, Columbia (King's College, New York) and the University of Pennsylvania, all had medical schools before 1775. Queen's College, Rutgers, offered prerevolutionary courses in "metaphysics, chemistry, botany, and anatomy," but no degree.

To attend Edinburgh, or even the American schools, required considerable substance, as well as social standing and position in the community. As a result, most aspirants studied under the preceptor method; and read and practiced under the men who had been graduated by the proprietary schools. Sometimes, after several years of reading and such practice, these men either went out on their own; or by recommendation, were admitted to one of the American schools. Rarely, one went on to Edinburgh. John Randolph of Bridgetown, now Rahway, did.

If we are to learn the status of surgery of the period of the American Revolution; this period, 1775 to 1783, we must search out the diaries of the wounded men, the diaries of the Revolutionary surgeons, the occasional article prepared for just such a meeting as this one, written by surgeons on successful results so long ago. Drs. Nathaniel Scudder of Monmouth Courthouse, now Freehold; Thomas Cooke of Holmdel; Elias Tilton of Tuckerton; and Charles Gilman[2] of Woodbridge, were some of the New Jersey men.

Tilton was attached to General Washington's staff. After the defeats at Forts Washington and Lee, the Army retreated across New Jersey. In camp at Plainfield, Gilman encountered Tilton and suggested that he, Tilton, give the General relief from his aching teeth. Washington's diary shows that he was suffering unmercifully at this time. Gilman suggested that Washington wash out his mouth with rum and then be given an ample dose of Tincture of Opium, to give him some much needed sleep. Tilton told Gilman to take care of his men and he would take care of his. The diary states: "Therefore, I avoided Tilton at all times." Colonel Scudder and Major Gilman, although medical men, each commanded line troops. Scudder, the Monmouth Militia; and Gilman, the Piscataway and Woodbridge Jersey Blues. Medical men unless in command of line troops, held no commissions.

Quite by accident, Dr. Gilman discovered the disinfecting properties of alcohol. "At the battle of 'Haarlem' Heights, I received a crease wound to the back of the hand. Painful, it would not heal and exuded laudable pus. In camp at Newburgh, I spilled—quite accidentally—for I had had too much rum, some upon the member. I covered it, and in two days I noticed no odor. I removed the cover and the wound was healing. Thereafter, all wounds were soaked in rum clothes before covering."

Dr. Scudder was an obstetrician in a time when midwives held the field. Scudder was at the head of his regiment as the Battle of Mon-

mouth joined on June 28, 1778. A patient, by the name of Thompson, rushed up and told the doctor that his wife was "about to be delivered of her torment." Torn between two duties, but true to his oath, Scudder accompanied Thompson to his home. Having completed his mission, he now found he was within the British lines, and so, from an attic window, watched the tides of battle flow back and forth. Finally, when the British were pushed from the field, Colonel Scudder, M.D., descended through a trap door from his undignified observation perch; met his men, and led them forward.

These were the men who constituted the backbone of American medicine and surgery. They could pull teeth, set a horse or human fracture, excise a tumor if it presented, evacuate an abscess, probe and remove a ball, and remove by Cesarean a baby after the mother had expired.

There is a tale told of a woman who lived in Vandenburg. She ceased to breathe during labor. Old Dr. Cooke of Holmdel, opened the abdomen and extracted a live baby. With great compassion and tenderness, he bound closed the abdomen after replacing the viscera. Suddenly, the woman gasped and began to breathe. He "introduced Jersey lightning by mouth." The woman lived and ultimately went on to help settle the Ohio Territory after the war. Dr. Cooke's office is still kept in fine condition. It consists of two rooms. A waiting room, pine panelled and a lovely fireplace partly covered by a beautiful colonial mantle with carved shell sun bursts. Built in deeply panelled colonial cupboards flank each side of this mantle. The second room, just as rich, was the treatment room. The outside consists of a square eighteenth century Georgian building with small panes and deeply panelled shutters. The Dutch door, divided and deeply and exquisitely panelled, is set in a frame with a sun burst above. This early doctor's office is on the McCampbell farm at Holmdel.

A diary shedding some light on the subject is this one of Thomas Clarke.

"Thomas Clarke's Journal of material Transactions kept out of curiosity and transcribed from other Books as I entered them, with the several dates, at the time when it happened. Drawn of by me in the year 1801 and so forwards Though in a Stile no ways Elegant but Plain."

Thos. Clark

Thomas Clark's Journal of transactions in his memory, begun the 4th. day of January one thousand Seven Hundred and Fifty Eight (1758).

Thomas Clark was Vice President of the Council of Proprietors for the Western Division of New Jersey, Member of Council of Safety and Committee of Observation for Gloucester Court, N. J. 1775, Member of both Provincial Congresses, Trenton, 1775, and New Brunswick, 1776, Member Gloucester Co., for the N. J. Assembly, Judge of Common Pleas and Orphans Court, Member of Legislative Council of New Jersey for Gloucester County, 1799-1803.

Dr. Bodo Otto was chief surgeon during the Revolutionary War at Valley Forge. His large box of instruments is deposited in the Historical Society of Berks County at Reading, Pennsylvania. The instruments in the cabinet look like so many tools. The Diary or Journal in copy form, is in the Gloucester County Historical Society, Woodbury, New Jersey.

Abstract:

"I built two houses in Philadelphia and gained nothing by them. During the time I lived on the Vanneman's Plantation, I had a Bad Spell of sickness with a White Swelling on My Right Thigh. Doctor Bodo Otto Senr. attended me. He wanted to cut off my leg above said Swelling. I would not suffer it but at last consented to have it Lansed as it Lay—Depp, as it Layat the Bone and he lansed it 3 Inches long and 2 inches Deep and there Came out a White Scum like unto a Hickery nut with Prongs, and as it healed I got well & Blessed God for it."

T. Clark.

No praise for the doctor!

We have read and heard told of the suffering at Valley Forge and Morristown. How the cries of the men could be heard for miles, while amputations were in progress. However, the diary of Major Charles Gilman,[2] M.D., states, "a good dose of tincture of opium followed by ample rum, together with a very sharp knife and sharp saw and ears covered with lamb's wool, and then the head bound

over (the ears) results in little discomfort to the man."

He also suggests pressure bandages to the stump at once. Sometimes the stump was seared with a hot iron.

In gun shot wounds, he recommends removal of the ball if possible, "but don't probe too long." Again, he used tight compression bandaging and the same for bayonet wounds. Gilman did not suture, but bound the sides together.

For snake bite, and there were many on the terrain over which this Army fought, "cross cut and let it run, be sure the cuts pass thru the bite, then cup."

Bleeding was standard practice for fevers. In fact, the controversy still goes on as to whether Washington might have survived had he not been bled so much and so frequently. Martha's diary presents her objections. Washington's physicians differed (sometimes violently) on the subject, but as long as the General was conscious, he ordered them to continue bleeding. A sharpened quill could be used for the purpose, but generally the surgeon's knife sufficed. Presenting abscesses or tumors were evacuated or excised. One of the most interesting discoveries I made was among old letters in Williamsburg, Virginia. A broken arm or leg was extended, traction was then exerted against the lower posts of a four poster. In one of Washington's diaries (there are thirty-two) is a not too bad sketch of a horse held off the floor in belly bands with weights drawing down the broken leg. When I was a boy, my father successfully did the same thing with a prize horse. The horse healed and lived a useful life.

In general, the quality of practice was in inverse proportion to the distance from large cities; but this was not always so. Then, as now, there were men at the frontiers like bone setter Reese, and (although much later) Dr. MacDowell of Kentucky and Colonel Beaumont of the frontier territory. These men rarely recorded their successes, so they died with them. We do know that the mold on jelly was believed good for colds. Penicillin? Perhaps. Cross cutting for snake bites then cupping (suction), traction and extension, laudanum and tincture of opium for pain, incision and drainage, wintergreen plant for headache and joint pains, sassafras, lime, cherry, and honey for bronchitis, and pressure bandages for hemorrhage. Hemorrhoids were incised. Teeth were always extracted by the surgeon. The man would then bite on a leaden ball. Heat from the open fire was good for the ague. Today, we know a wood fire is rich in infra-red, particularly if its rays are reflected by an iron fire back. Salt was used to arrest bleeding and is still used following the castration of hogs.

Instruments of Major Charles William Gilman, M.D., of Woodbridge, N. J. In the background from left to right: alabaster jar made by the forerunner of the Woodbridge Salamander pottery works; next, two mortars, the one on the extreme right several hundred years old. Front row left to right: a suppository press, horn spoons, surgical instruments in a beautiful mahogany case, above the case a "looking glass," to the extreme right, a tooth extractor.

Sergeant Charles Gamberton of Woodbridge, a Jersey Blue,[3] was shot through the face at Monmouth. The ball went through his cheek, struck his teeth and stopped. "I spat it out" (the ball, not the teeth). A very tight compression bandage by Gilman 'healed it quickly," according to Gamberton. Gamberton's daughter, Suzanne, later married Dr. Gilman's son, Charles.[2]

Dr. Craik, Washington's home physician, packed wounds to arrest bleeding. Many practitioners said let it bleed; if it bleeds too much sear it. Others recommended a compression ("wad of cloth tight and firm"). This

sort of treatment continued well beyond the Civil War. A study of the care of Lincoln shows that the men just stood by helplessly. Occasionally they probed, then exerted compression over the wound.

ONE of the outstanding stories of the pre-Revolutionary period, is that of Penelope Stout. This story appears in *Heroic Women of America* (New Jersey Historical Collections by Barber and Howe) and in Loessing's *Field Book of the American Revolution*. Penelope crossed the bay from Middletown to Sandy Hook Island, to pick beach plums, a fruit for which the Hook is still famous. She was beset by foreign Indians who slashed her abdomen until all the viscera protruded. She was left for dead. These were the same Indians which caused the towns of Piscataway and Woodbridge to set up a militia as early as 1673. The council stated in Liber I of Piscataway and Woodbridge Town Records: "This company is formed to repel foreign Indians who come down every summer from Upper Pennsylvania and Western New York and gourge themselves on fishes and clambs and on their way back, get drunk and burn corn stalks, hay stacks and even barns, and make a general nuisance of themselves." This company was the origin of the Jersey Blues.[3]

Two hunters found Penelope, replaced her viscera, bound her up securely with "clothes," carried her across the bay, placed her on a bed of pine boughs and transported her to Middletown twelve miles away. She lived to the age of 94, had 14 children and is the progenitor of all the Stouts in New Jersey, as well as elsewhere. Co-aptation by binding seems to have been the standard practice. I can find no evidence of suturing during this entire period. Some medical historians assert that horse hair was used. But I would like to find the factual source—not hearsay.

From the time of the invention of gun powder and the first arquebus, burns were a real problem to the man of arms. He had to worry about flashbacks from the pan, flashbacks from the touch hole, or even burns from handling and firing a cannon too rapidly, not to forget massive flashbacks from the muzzle as a result of loading and firing too rapidly while pieces of burning wadding were still present. Everything from mud and grease to human urine was tried for treatment. By the time of the Revolution, strongly steeped China tea applied as wet dressings, then wrapped with cloth, became the thing of choice.

At the Battle of Monmouth, apparently General Clinton thought Washington's surgeons were better than his own. He left a church full of wounded at St. Peters in Freehold, and the following note: "I command them to your Christian care."

Progress in surgery was retarded for ages because of dogma, superstition, intimidation and fear. But medical progress is conspicuous during and just after wars. The conclusion is obvious. Science advances more rapidly with the exchange of ideas. The first great steps were taken about the time of the American Revolution, by the visionary men who founded The Medical Society of New Jersey and the first medical schools in the colonies. Then, and only then, was the yoke of irregular practice and restraint finally broken. But progress was still slow, for the complimentary sciences were yet to come and did not come until after the Civil War—in fact not until after 1875.

MILESTONES OF AMERICAN MEDICAL HISTORY 1750 - 1800

1750—John Bard (1716-1799) and Peter Middleton (1720-1781) present systematic dissection for purpose of instruction in New York.

1751—The Pennsylvania Hospital, the first general hospital in Colonial America, opens in Philadelphia.

1752—Benjamin Franklin (1706-1790) designs first flexible catheter in America.

1755—William Hunter (1730-1777) presents first publicly advertised systematic lectures on anatomy with dissection in Newport, R. I.

1757—Thomas Walker (1715-1749), of Virginia, trephines bone suppurative osteomyelitis.

1759—John Bard (1716-1799) reports a case of extrauterine pregnancy.

1762—William Shippen, Jr. (1736-1800) starts his famous anatomy course in Philadelphia with demonstration on cadaver.

1765—John Morgan (1735-1789) and William Shippen, Jr. (1736-1800) found medical department of College of Philadelphia, forerunner of University of Pennsylvania. Shippen presents first lectures on obstetrics.

1766—Establishment of The Medical Society of New Jersey. This was the first state medical society in America. Thomas Bond (1712-1784) presents first clinical (bedside) course in America.

1767—Organization of medical school at King's College in New York, forerunner of Columbia University College of Physicians and Surgeons.

1773—First mental hospital in America opened at Williamsburg, Virginia.

1775—Colonial Army medical department is first established.

1782—Harvard Medical School is founded.

1784—Benjamin Franklin (1706-1790) invents bifocal eyeglasses.

1787—The College of Physicians of Philadelphia is founded.

1788—Hezekiah Beardsley (1748-1790) of Connecticut, first describes congenital hypertrophic pyloric stenosis.

1790—William Boynham (1749-1814) of Virginia, reports cases of extrauterine gestation in 1790 and 1799. He also (in 1790) discovered vascularity of the rete mucosum.

1794—Jesse Bennett said to have performed first cesarean section in America.

1798—Medical department of Dartmouth College founded.

1800—Benjamin Waterhouse (1754-1846) introduces vaccination in America.

Blossom Cove Farm

BIBLIOGRAPHY

1. Really, Breed's Hill.

2. The author is the fifth generation lineal descendant of Major Charles Gilman, M.D. By deed of gift, his instruments, pistols, diary and Bible are the property of the author.

3. "The Jersey Blues" is the oldest regiment in continuous service in the western world. Organized in 1673 at Piscataway and Woodbridge, New Jersey, they fought in the Colonial, Revolutionary, Civil and Spanish-American wars.

The Death of Washington, by Dr. James Craik.

The Death of Lincoln, Archives, Smithsonian Institute.

Diary of Charles Gilman, Woodbridge, New Jersey.

Gilman Bible, Woodbridge, New Jersey.

History of Medicine and Medical Men in New Jersey to 1800, Wickes.

Pioneer Mothers of America Series, Green.

Army Museum, Washington, D.C.

Nathaniel Scudder, M.D., New Jersey Archives, and Monmouth County Historical Society Records.

Dr. John Cook, New Jersey Archives, and Monmouth County Historical Society Records.

Diary of Thomas Clark, Gloucester County Historical Society, Woodbury, New Jersey.

Diabetes of the Poor

Pancreatic fibrosis is the diabetes of the poor. So says P. J. Zuidema writing in the Amsterdam (Netherlands) *Tijdschrift voor Gastroenterologie* (3:77, January, 1960). He points out that of 45 patients with pancreatic fibrosis, 18 had radiologically demonstrable calcification. Most were under 35; there were 32 males to 13 females. In 43 patients severe diabetes mellitus dominated the clinical picture. Many were insulin-resistant. Complications were present in a high proportion of cases, the patients having sought medical advice only after impairment of vision by cataract had developed.

The calcareous deposits were scattered throughout the pancreas in 16 patients, whereas in 2 they were confined to the head of the gland. In some cases the pancreas had dwindled to a narrow ribbon ("petrified pancreas").

The commonly held view that pancreatic fibrosis is ultimately caused by chronic pancreatitis is rejected. The cause is thought to be a protein-deficient diet. All the patients belonged to the poorest classes and their diet was lacking in animal protein; pancreatic lesions occur in kwashiorkor; swelling of the parotid glands was present in 16 patients and changes in the scalp hair in 15, these being common signs of protein malnutrition.

The nature of this "diabetes of the poor" is not clear. In view of the extensive lesions, a type I diabetes sensitive to insulin with a tendency to acidosis would be expected; but quite the opposite was found.

Board of Trustees

MAY 13, 1960 MEETING

At the May 13 meeting of the Board of Trustees, the following matters were referred to the House of Delegates: (1) the report of the Finance and Budget Committee; (2) a proposed program for professional liability insurance; (3) nominations to the Board of Trustees of Medical-Surgical Plan; (4) nominations for the Board of Governors of Medical Service Administration; (5) consideration of the discontinuance of the diagnostic rider by Medical Surgical Plan if the Hospital Service Plan also agrees to discontinue the diagnostic rider under Blue Cross; (6) commendations for Dr. Allman and Dr. Costello.

The President reported that since the last meeting there had been an increase in the number of physicians who have indicated willingness to participate in the special Senior Citizens Contract. In the past month two additional counties have exceeded the required 51 per cent.

The Board authorized the renewal of the Medicare contract for 1960-61 and the supplemental agreement.

The Trustees referred to the A.M.A. delegates a communication from the Gloucester County Medical Society asking the delegates to oppose the discontinuance of the accreditation of medical schools.

The Trustees gave a rising vote of thanks to Drs. Gardner, Sica and Donnelly for their efficient service on the Board of Trustees during the past years.

MAY 17, 1960 MEETING

The reorganization meeting of the Board of Trustees was held on May 17 at Atlantic City.

Dr. Mulligan was elected Chairman of the Board for 1960-61, and Dr. Kaufman was elected Secretary for the same period.

Dr. Samuel J. Lloyd was elected to membership on the Committee on Finance and Budget for the 1960-63 term.

Dr. Joseph Donnelly was named as alternate delegate to attend the 1960 meeting of the American Medical Association.

All salaried personnel, excluding those on contract, were reappointed for 1960-61 at the salaries set forth in the budget.

Acknowledgment was ordered sent to the staff of Haddon Hall for their fine cooperation during the convention.

On motion, the Board agreed to meet the third Sunday of every month.

The President was authorized to send a letter to each County society stating that the State officers are willing to visit any society on invitation and requested that that letter be read in an open meeting.

New Professional Liability Plan

The following information is supplied by the Committee on Medical Defense and Insurance:

On June 26, 1960, the Board of Trustees of The Medical Society of New Jersey acting upon authorization given by the 1960 House of Delegates—officially designated the American Mutual Liability Insurance Company as the professional liability insurance carrier for the members of The Medical Society of New Jersey. Under terms of the agreement entered into, coverage is available to all members in good standing of The Medical Society of New Jersey. No cancellation of coverage by the company will be made except after consultation with the Society.

Limits from $5,000 per person and $15,000 aggregate to $250,000 per person and $750,000 aggregate may be elected by the individual

member. The minimum coverage limits recommended by the Carrier are $100,000 per person and $300,000 aggregate.

The classifications and rates used initially are those established by the National Bureau of Casualty Underwriters. Subsequent modification of rates will be governed by the loss experience of the members of the Society.

To members of the Society carrying professional liability coverage with American Mutual, the company has agreed to make available this coverage for not only their vicarious liability but also for the individual liability of physicians, registered nurses, and qualified technicians in their employ.

Professional Premises Liability Coverage is also being made available to all members in good standing of The Medical Society of New Jersey. Placement of this coverage and Professional Liability Coverage with the American Mutual will minimize questions of coverage, controversy as to protecting Carrier, and delays in the processing of claims.

As an added protection for members called upon to function in official capacities, the Society has arranged for libel, slander, or defamation of character coverage. This coverage applies to The Medical Society of New Jersey and its component societies and to "an individual acting within the scope of his duties as an officer or employee of The Medical Society of New Jersey or of a component county medical society of The Medical Society of New Jersey, or committed by any individual acting within the scope of his duties as a member of a duly authorized committee of The Medical Society of New Jersey, or any component society, or an accredited or licensed hospital . . ."

A distinguished and desirable feature of the Society's new insurance plan with American Mutual is the Loss Control Program. In consequence of long years of experience in the field of professional liability insurance the company is convinced that the reputation of physicians, the welfare of patients, and the maintenance of favorable rates are all dependent upon close and cooperative effort on the part of the company and the Society.

Fundamental to the Loss Control Program is the efficient operation of county medical society committees, with representation from the chief areas of specialty practice. These committees, working in conjunction with representatives of the American Mutual and legal counsel, will review all claims under the policy. Emphasis will be placed on the medical and legal aspects of each claim. Issues will be defined and a conclusion reached with respect to the disposition of the claim.

A descriptive brochure has been prepared by American Mutual outlining coverage rates, and advantages of the Plan. Each member of the Society will receive a copy.

Questions concerning the Plan should be addressed by members to:

> Mr. Joseph A. Britton, Manager
> American Mutual Liability Insurance Company, Professional Liability Department, 68 South Harrison Street, East Orange, New Jersey.

Each member of the Society is urged to check the expiration date of his current policy and to support the new plan which has been adopted and is recommended by The Medical Society of New Jersey.

New Jersey Diplomates in Gynecology

The following New Jersey doctors were certified by the American Board of Obstetrics and Gynecology on April 15, 1960.

For Single Certification in Gynecology Only —

Anthony P. Caggiano, Upper Montclair
C. Gregory Caltabiano, Dumont
Adolph B. Clachko, Hackensack
Albert M. Doswald, Bound Brook
Ernest P. Geenberg, Union
Severin T. Golojuch, New Brunswick
William M. Griffin, Hackensack
William H. Hayling, Newark
Earl I. Kanter, Margate
Herbert Langer, Cranford
Frank F. Liegner, Newton
George M. Massell, Red Bank

Certified in 1958, in Gynecology Only —

John C. Mutch, Moorestown
Frederick L. Perl, Bound Brook
Charles A. Rentrop, Jr., Ridgewood
Arthur J. Ruccia, Newark
Paul E. Stroup, Collingswood

Pilot Plan for Eye Care on Funded Payment Basis

The below described "Pilot Plan" for Eye Care on Funded Payment Basis—proposed by the Special Committee on the Conservation of Vision and approved by the Board of Trustees last year—was referred back by the 1960 House of Delegates for further study; and the House directed that the "Plan" be published and circulated to the membership for detailed examination before any implementation is undertaken.

The Board of Trustees, at its meeting on June 26, 1960, directed that the "Plan" be published in THE JOURNAL. The Board further directed that following publication of the "Plan" the Executive Offices ascertain the opinion of the "Plan" from each component society.

1. Basic medical eye care to be provided by ophthalmologists who choose to participate. could be made available to organized groups such as unions or management desiring to arrange for it on a funded basis, by means of a non-profit organization representing the participating physicians. Such an organization might be identified as "Ophthalmologic Service Plan," hereinafter called the Plan. The Plan would not raise funds or in any way offer insurance, but would provide a single agency to which interested unions could turn and which could speak for participating physicians. The Plan would have a board of trustees chosen from the participating physicians. It would, of necessity and desire, comply with all principles and policies of the AMA, as established by the House of Delegates, and be subject to the scrutiny of the State Medical Society. The support of an adequate number of ophthalmologists in a county would be required for the program to function effectively. All qualified licensed physicians would be eligible to participate.

2. It would be the responsibility of the Plan to:

a. Enroll as "Participating Physicians" licensed physicians specializing in ophthalmology (but not necessarily limiting practice to ophthalmology).

b. Make available the individual services of participating physicians, in providing basic medical eye care on a group basis, under the following conditions: Free choice of physician, service to be rendered in physician's office in his private practice as any other private patient, fee-for-service basis fees stipulated by the Plan. The Plan would make available two services from physicians: Service A, to all eligibles desiring it; and Service B, to those found by the physician to require it. These services are not available under the above conditions from any existing plan.

Service A: Examination (including refraction, tonometry, and mydriatic ophthalmoscopy unless contraindicated), medical diagnosis (provisional, if definitive not possible), basic treatment (prescription of glasses, initial prescription of medication as indicated), and referral for further medical care if indicated. This service would be provided in one or more visits according to circumstances and the physician's usual practice. Subsequent inspection of the prescribed glasses by the physician for accuracy and fit and their acceptance or rejection by him, is part of this service, as is the occasional follow-up visit in the infrequent case where the patient requires guidance and advice in the period of adjustment to his glasses.

Service B: Provision of glasses, if required, and services incident thereto. These incidental services include taking facial measurements, writing specifications (in addition to the lens prescription) which the laboratory requires to make the glasses, inspection of the laboratory product with reference to the prescription and specifications, fitting and adjustment of frames to maintain comfort and proper fit, for two years. The individual physician would follow his usual custom with respect to rendering or delegating to an optician the rendering of this service, but retaining his full responsibility and authority. When the service is delegated the fee for this service would be totally assignable to the optician.

c. Establish fees for Services A and B acceptable to participating physicians in the respective area. The fee for Service A would be constant whether or not medications and/or glasses are prescribed. The fee for Service B would include the actual cost of the glasses.

d. Provide a list of participating ophthalmologists.

e. Formulate agreements covering a fixed period of time with organized groups (labor union or management, welfare fund, etc.) covering necessary procedures, including payment to the physician; represent participating physicians in all relations with the organization representing the eligible patient. Fees would be subject to revision by the Plan after expiration of agreement. (It is anticipated that an agreement would not cover a period longer than two years and initially it might be essential to limit to a short period for an experience study.)

3. Services Not Covered:

a. All surgical procedures.

b. All treatment for injury under any circumstances.

c. All in-hospital services.

d. All office treatment after the initial visit for other than refractive conditions, including field examination and its interpretation and other special diagnostic procedures.

e. Any other services available under Blue Shield.

f. All conditions subject to compensation insurance.

The excludable services are insurable, coverage for them is purchasable, and they present to the ophthalmologist no problems different from those of his colleagues in other branches of medical practice.

4. The Participating Physician would:

a. Render services in his office as outlined above as he would to any other private patient.

b. File claim and bill, indicating if glasses have been prescribed and supplied, and designating optician to be compensated, if any.

5. The Funding Group would:

a. Provide for the payment of fees to physicians (and opticians as designated) for the services rendered, and provide at its own expense all administrative services necessary to process claims at that organization's level.

b. Identify the Plan to its members as the physician's service organization making the program available and make the Plan's list of participating ophthalmologists available to the organization's members.

Such a Plan could come into being through the voluntary action of ophthalmologists in Essex County. The committee notes that in accordance with the AMA position adopted by the House of Delegates in June, 1950, if any organization chose to make arrangements with a closed panel and individual physicians accepted such proposal, those physicians would not be regarded as unethical. It is the opinion of the committee that the Plan outlined herein would be much better for the public, and might act as a deterrent to the development of closed panel plans.

Honor for Mary Bacon, M.D.

A highlight of the June meeting of the Cumberland County Medical Society this year, was the adoption by acclamation of a resolution acknowledging the valuable and effective services to the Society of Dr. Mary Bacon. The text of the resolution follows:

Whereas: Mary Bacon, M.D., has practiced medicine at 278 E. Commerce St., Bridgeton, N. J., for 43 years, and

Whereas: Dr. Bacon has served faithfully as President and Secretary of the Cumberland County Medical Society and is presently resigning the latter position, and

Whereas: Dr. Bacon has served in such capacities as: Chairman of the County Maternal and Infant Welfare Committee; Chairman of the Perinatal Committee of the Bridgeton Hospital Staff: a member of the Maternal and Infant Welfare Committee of The Medical Society of New Jersey; a Field Worker for the Maternal and Child Health Division of the State Department of Health; Chairman of Delegates from the Cumberland County Medical Society to The Medical Society of New Jersey; Chairman of a Reference Committee in the House of Delegates; Secretary of the Obstetrical and Medical Sections of the Bridgeton Hospital; a member of the New Jersey Obstetrical and Gynecological Society; also the Academy of Medicine of New Jersey and the American Academy of General Practice, and

Whereas: Dr. Bacon has augmented this auspicious record by 36 years of marriage to a most unusual and understanding husband, J. I. Caruthers, the marriage yielding two living daughters, two grandsons and two granddaughters.

Now Be It Resolved: That the Cumberland County Medical Society acknowledge Dr. Bacon's many years of service with deep appreciation; spread this resolution on its minutes and send a copy to Dr. Bacon and arrange to have the same placed in THE JOURNAL of The Medical Society of New Jersey.

In addition to the activities enumerated in the resolution Dr. Bacon was a dynamo in the development and operation of the nurses' training school at Bridgeton Hospital where she taught obstetrics for 17 years.

Encephalitis and the Private Practitioner

Last summer there was great public concern over an apparent outbreak of encephalitis, particularly in the New Jersey shore areas. While no such experience is likely to recur within the next few years, the possibility is always there. In addition to the direct professional care problem involved, every doctor also has a semantic problem: what to tell the family. Our Health Commissioner, Dr. Kandle, suggests that the phrase "central nervous system illness of presumed viral etiology" be used instead of the easily misunderstood, panic-producing term "encephalitis"; or at least that the broader phrase be used until history, examination, and findings (including spinal fluid analysis) justify a more specific diagnosis.

Dr. Kandle further advises us as follows:

"While is is required that the diagnosis of poliomyelitis, aseptic meningitis and the sequelae of measles, varicella or mumps be reported in accordance with an established plan promulgated to hospital administrators and boards of health, *it is requested that any physician who has the conviction that he is dealing with suspected viral encephalitis, communicate directly by telephone with any one of the following persons*:

Name	Office Tel.	Home. Tel.
Roscoe P. Kandle, M.D.	EXport 2-2131, Ext. 8305	TUxedo 2-5259
William J. Dougherty, M.D.	EXport 2-2131, Ext. 8305	EXport 6-6067
Jesse B. Aronson, M.D.	EXport 2-2131, Ext. 8491	OWen 5-0675
Martin Goldfield, M.D.	EXport 2-2131, Ext. 8357	TRiangle 7-0615
Hugh D. Palmer, M.D.	HAzel 9-7550	HAzel 9-2474
Geoffrey W. Esty, M.D.	EXport 2-2131, Ext. 8413	WAlnut 4-1565
Miriam Sachs, M.D.	MArket 4-1414	REdwood 1-0938
Harry Nicholas	JUstice 4-8121	JUstice 4-5138

"Sound public health and medical practice requires that the diagnosis of these diseases be supported by virologic studies. Physicians and pathologists are invited to use the facilities of the Virus Laboratory of this Department in confirming or ruling out clinical diagnoses of central nervous system disease. Note below further instructions on specimen collections.

"In the face of the dramatic outbreak of encephalitis last year, the medical profession, as usual, responded magnificently. Your cooperation made possible an accurate and extensive scientific documentation of the events of the outbreak. We face the coming summer with calm assurance that with the practitioners of this State we will maintain an alert, cooperative surveillance. We have confidence too that New Jersey's fundamentally healthful environment has not been changed."

Sincerly yours,

ROSCOE P. KANDLE, M.D.
STATE COMMISSIONER OF HEALTH

If You Have A Suspected Case of Central Nervous System Disease of Viral Etiology

1. Obtain a specimen of clotted blood in a sterile dry tube as soon as possible.
2. Arrange for collection of 3 stool specimens and an aliquot of spinal fluid for virologic studies.
3. Communicate with hospital pathologist who will arrange for the proper storage and shipment of specimens to laboratory.
4. Complete a request form for virologic services (Form Vir-10) which will be available from hospital pathologist.
5. Collect convalescent specimen of clotted blood 4 weeks after onset, submit to hospital pathologist for shipment to laboratory.

Supplementary List No. 6

to the

1959-60 Membership Directory

Memberships reported from June 11, 1960 through July 10, 1960

R—Reinstated
N—New

	Name	Address	County	Practice
		ACTIVE MEMBERS		
N	Fushille, Michael	83 Van Nostrand Ave., Jersey City	Hudson	....
N	Heffernan, Evelyn D.	31 Seven Bridge Rd., Little Silver	Monmouth	Int Med
N	Heffernan, John F.	31 Seven Bridge Rd., Little Silver	Monmouth	Int Med
N	Vedovic, Angela M.	25 Reckless Pl., Red Bank	Monmouth	Ob Gyn
		ASSOCIATE MEMBERS		
	Bristow, William H., Jr.	Bergen Pines Hosp., Paramus	Bergen	Psy
	Colantuono, Frank	234 Columbia Ave., Fort Lee	Bergen	Ped
	DeAndrade, Ronaldo	172 Franklin Ave., Ridgewood	Bergen	Ped
	Erem, Nejat	100 Main St., Lodi	Bergen	Gen Surg
	Feinberg, Sheldon N.	190 Rivervale Pl., River Vale	Bergen	Ped
	Galassi, Mario F.	25 Reckless Pl., Red Bank	Monmouth	Ped
	Garra, Victor S.	846 Saddle River Rd., Saddle Brook	Bergen	General
	Hare, George T.	29 San Diego Dr., Magnolia	Camden	Resident
	Loreti, Michael R.	387 Passaic St., Hackensack	Bergen	General
	McMahon, Edward F.	Schering Corp., 60 Orange St., Bloomfield	Union	Clin Res
	Mitrovic, Vojslav	N. J. State Hosp. at Ancora, Hammonton	Camden	Hospital
	Pugliese, Girolamo	83 Main St., Keyport	Monmouth	....
	Rink, Heldi	Cooper Hospital, Camden	Camden	Anes
	Taylor, Robert L.	16 Brookdale Gardens, Bloomfield	Essex	General
	Vanace, Peter W.	Camden Municipal Hosp., Camden	Camden	Ped
	Waleson, M.	46 Johnson Ave., Newark	Essex	Gen Surg
	Wheaton, Earl A., Jr.	130 Prospect St., Ridgewood	Bergen	Int Med
	Yale, Noyes E., Jr.	6 Oak Ave., Tenafly	Bergen	Int Med

Medical Films Available

Films available from the A.M.A. motion picture library are listed in a new catalog which outlines 175 medical films suitable for showing to medical societies, staff meetings, and other scientific groups. Also listed are 81 health films for physicians who speak before lay audiences such as service organizations and Parent-Teacher associations. The catalog has a subject index, alphabetical listing of film titles, order blanks and color coding so that films may be quickly identified. Copies of this catalog may be obtained without charge from the AMA Department of Medical Motion Pictures, 535 North Dearborn Street, Chicago 10, Illinois.

Letters to The Journal • • •

"Eradication of Tuberculosis"

Dear Sir:

The physicians of New Jersey can eradicate tuberculosis from the state. This statement may appear to be an exaggeration, but there is no known reason why the incidence of tuberculosis cannot be reduced almost to the vanishing point.

The method proposed is simple. Treat every positive tuberculin reactor.

In most communities, tuberculin tests are administered to every school child through age 18. If the positive reactors among these are all treated many will be saved from future clinical tuberculosis. It would be ideal to survey the entire population for tuberculin reactors, but this might be considered to be too much of a task. However, the practicing physician can test all of his patients as well as pre-school children.

The tuberculin test should be intradermal. The preparation is P.P.D. (purified protein derivative) intermediate strength and the dose is 0.1 of a cubic centimeter. It should be read after 48 to 72 hours. If an indurated area of 5 millimeters or more, measured with a rule, is present the reaction is positive, and this individual must be considered to be infected with tuberculosis.

The steps which should be taken follow:

1. Physicians, particularly general practitioners, pediatricians, and internists, should get in touch with the local school physician and local health department to urge that all school children who react to tuberculin be referred to their physicians or to a clinic. Physicians should urge that skin testing be done in those districts where it is not now done.

2. Physicians should test all pre-school children in their offices and in any clinic in which they work. They should also test all of their adult patients.

3. All positive reactors should be x-rayed. Those who have x-ray evidence of disease should be managed as clinical problems.

4. Those who react to tuberculin but show no demonstrable x-ray lesions should be treated with isoniazide. The dose is 10 milligrams per kilogram per day, with an average maximum of 400 milligrams per day. One year's treatment should be adequate.

It is most important that the physician use some follow-up system to be sure that the tablets are taken.

5. Current and projected case finding programs of the various health departments and tuberculosis leagues should be continued. Cases referred by those agencies to physicians are usually clinical problems and should be managed as such.

David Biber, M.D.
Union

Obituaries • • •

DR. GEORGE N. J. SOMMER

On June 20, death ended the notable career of George N. J. Sommer, dean of Trenton surgeons. He was the Senior Fellow of our Society—and except for Dr. Hawkes, our oldest living past president. Dr. Sommer was born in Trenton in 1874. In 1894 he received his M.D. at the University of Pennsylvania. He interned in Philadelphia and then did graduate work in the then new and exciting field of bacteriology at Johns Hopkins. Dr. Sommer then went to Germany for further graduate study. He then entered private practice—first general practice, then gradual concentration on surgery—particularly in urology, in which field he was a Delaware Valley pioneer. He passed through all the offices in the Mercer County Medical Society, becoming president of that component in 1900. In 1930 he became President of The Medical Society of New Jersey. He was medical director of St. Francis Hospital in Trenton and consultant to many hospitals. For editorial comment on Dr. Sommer's death, see page 451 this Jounral.

Announcements • • •

AMA Honor for Dr. Costello

Dr. William F. Costello, a member of our Morris County Medical Society, was elected vice-president of the American Medical Association at its Miami meeting in June 1960.

N. J. Woman Doctor Wins Art Award

For the first time in history, a woman won the "Best of Show" award at the American Physicians Art Association exhibit held in connection with the AMA Convention in Miami in June. The winner, Dr. Dorothea D. Vann of Englewood, N. J., is a member of the Bergen County Medical Society. The award-winning picture was a still life in oil, called "Reflection."

Aero-Space Medical Seminar

The New Jersey Flying Physicians Association will conduct an Aero-Space Medical Seminar at the National Aviation Facility Experimental Center in Atlantic City on the afternoon of September 25. Cocktails and dinner will follow the seminar.

All Flying Physicians Association members and interested physicians are invited to attend.

Detailed program may be obtained from Dr. James L. Garofalo, 107 Smull Ave., Caldwell, New Jersey.

Course in Psychosomatics

Starting on October 5, 1960, Philadelphia will be the site of a 4-hour-a-week, 20-week course in psychosomatics. The course is sponsored by Temple University's departments of obstetrics, medicine, psychiatry and gynecology and will cover diagnosis and management of physical disorders rooted in emotional conflict. Tuition is $40. For details, write to Dr. H. Keith Fisher, Psychosomatic Course Director, 100 West Coulter Street, Philadelphia 44, Pa.

Audiology Course Offered

A short course in audiology is offered several times each year by the Temple University School of Medicine, Philadelphia 40, Pa. The one-week intensive program will encompass theoretical and clinical aspects of audition. Hearing testing and interpretation will be stressed. Office procedures, equipment and industrial audiometry will be discussed.

Further information may be obtained from Philip E. Rosenberg, Pa.D., Director of Audiology, Temple University Medical Center, 3401 North Broad St., Philadelphia, Pa.

Graduate Courses in the Bronx

Montefiore Hospital announces an extensive program of graduate courses for the 1960-61 season. Almost every specialty is represented including cardiology, angiology, vascular surgery, hematology, peripheral vascular disease, gastroenterology, chest disease, neoplastic medicine, and ophthalmology. These courses are sponsored by Columbia University. For details write to Secretary for Medical Instruction, Montefiore Hospital, Bainbridge Avenue, New York 67, N. Y.

Urology Award

The American Urological Association offers an annual award of $1000 (first prize of $500, second prize $300, and third prize $200) for essays on the result of some clinical or laboratory research in urology. Competition is limited to urologists who have been graduated not more than ten years, and to hospital interns and residents doing research in urology. For details, write to William P. Didusch, 1120 North Charles Street, Baltimore, Maryland. Essays must be in his hands before December 1, 1960.

County Society Reports • • •

Atlantic

The regular meeting of the *Medical Society of Atlantic County* was called to order by President Louis Rosenberg at 9:15 p.m. on March 11 at the Children's Seashore House.

Dr. Josiah McCracken, Jr., introduced the speaker for the evening, Jonathan E. Rhoads, M.D., Professor of Surgery, University of Pennsylvania. His subject was "Problems of Modern Day Medical Education."

During the subsequent business session, Dr. James Mason read a resolution in memory of Dr. Harold S. Davidson. This was spread upon the minutes. A copy of the resolution will be mailed to members of Dr. Davidson's family.

Dr. Rosenberg referred the new applications for membership to the Credentials Committee Chairman, Dr. Peter Marvel. This is the first of the new forms to be completed. Some applicants who have been accepted by the Society from November through the first of March have been approved; but their credentials are also going to be passed through the regular channels so that they may be properly processed.

Dr. Clarence Whims stated that he had heard that the Woman's Auxiliary was planning to disband. After ample discussion a resolution prepared by Dr. Allman was passed. In this resolution, we salute and commend our Woman's Auxiliary and instruct the Liaison Committee to enlarge to seven members, and to cooperate to its fullest with the Woman's Auxiliary and encourage its activities.

Dr. Whims also discussed the raising of funds for a fellow physician who was in dire financial straits. He raised $1155 from 61 doctors and had only one refusal. The Medical Society praised Dr. Whims and commended him for his foresight and fortitude in launching this program for a desperately ill physician. This is one of the most considerate undertakings in the association of medicine in this community.

Dr. Rosenberg appointed the following nominating committee: Dr. Peter Marvel, chairman; Dr. G. Ruffin Stamps; Dr. Robison Harley; Dr. E. Harrison Nickman; Dr. Levi Walker.

We received a letter from Mr. Richard I. Nevin stating that the Golden Merit Award would be given to members of the class of 1910. A search of our files revealed that no one in our Society had graduated from medical school in that year.

With no further business, the meeting was adjourned.

The regular meeting of the Society was called to order by President Rosenberg at 9:00 p.m. on April 8 at the Children's Seashore House. Mr. Albert Marks of Newburger and Company introduced the guest speaker, Mr. Fredrick H. Levis, Vice-President and Director of Lionel D. Eie and Company. His subject was "The Doctor and His Investments."

This was an enlightening evening for everyone and Mr. Levis, a most capable individual, gave a much enjoyed talk.

Mr. Joseph Hackney, Director of Civil Defense, gave a brief outline of what was new in that field. He pointed out the great need for more knowledge and more cooperation. He stated that there are now four complete 200 hospital bed units available in Atlantic County and 100,000 bottles for blood at First Aid Stations. He showed a very interesting motion picture which explained newer concepts in Civil Defense.

At the business meeting Dr. Peter Marvel, reporting for the Committee of Credentials, presented three applications which were approved for associate membership. They are Drs. Leonard Stefy, Albert Hill, and Stanley Rogers.

Dr. Harvey Vandegrift presented the following memorandum concerning the Liaison Committee to the Woman's Auxiliary:

The Liaison Committee to the Woman's Auxiliary to the Medical Society of Atlantic County met on March 30 with Drs. Vandegrift, Molitch, and McCracken present, and have compiled the following statements and recommendations:

1. There is certainly a long history of accomplishments of the Woman's Auxiliary to the Medical Society of Atlantic County.
2. There is still a need for the Woman's Auxiliary as the past has proved, and some of the other Societies in the state have shown.
3. The Committee believes that the Woman's Auxiliary to the Medical Society of Atlantic County should continue its efforts with the cooperation of the Medical Society.
4. All members of the Medical Society of Atlantic County should encourage their wives to become active members of the Woman's Auxiliary.
5. The Liaison Committee of the Medical Society of Atlantic County, which has been appointed every year, offers its services if they are desired by the Woman's Auxiliary at any time. The Society's Liaison Committee of both organizations must have a meeting at the beginning of each year.
6. The Medical Society of Atlantic County Liaison Committee suggests one social function to be run by the Medical Society and the Auxiliary in September of each year, in lieu of a September meeting. This could be arranged by the Entertainment Committees of the two organizations. There should also be a combined meeting with a common speaker at a regular meeting date each year, preferably in January or March. All other meetings should be held separately by the Medical Society and the Auxiliary.

Dr. David B. Allman spoke on Bill 556 which had been sent to all physicians. This bill would allow the Commissioner of Banking and Insurance to regulate fees for physicians. Our society went on record as being opposed to this bill. Telegrams have been sent to Assemblymen and our Senator.

A letter was received from Dr. Frank Konzelmann in reference to the Shore Memorial Hospital Blood Bank. The Society unanimously approved the blood bank and a letter was sent to Dr. Konzelmann congratulating him on his work.

LEONARD B. ERBER, M.D.

Reporter

Bergen

The regular annual installation meeting of the *Bergen County Medical Society* was called to order by President Hull on June 7, at the Steak Pit, Paramus. There were approximately 96 members and guests present.

The President introduced the following guests: Mr. Victor Banta, President, Bergen Community Blood Bank; Dr. Joseph C. Banyar, President, Bergen County Dental Society; Mr. Donald G. Borg, Publisher, *Bergen Evening Record*; Mr. William Caldwell, President, Bergen County Chapter, American Cancer Society; Mrs. John V. Gazzola, Chairman, Bergen County Chapter National Foundation; Mr. Henry W. Holman, President, Bergen County Tuberculosis and Health Association; Mr. Ben Obolsky, President, Bergen County Pharmaceutical Association; Mr. Martin S. Ulan, Administrator, Hackensack Hospital; Dr. Harris K. Cohan, Administrator, Hasbrouck Heights Hospital; Mr. Nicholas T. Verrastro, Administrator, Pascack Valley Hospital; Mr. Richard I. Nevin, Executive Officer, The Medical Society of New Jersey; Dr. John Bedrick, Hudson County Medical Society; Dr. Joseph P. Donnelly, Hudson County Medical Society; Dr. F. Albert Graeter, President, Passaic County Medical Society; Dr. Joseph Jehl, Passaic County Medical Society; Dr. Emanuel Satuisky, Union County Medical Society.

The Secretary read the following names of new members present, who were elected during the year and asked each to rise: Drs. Ambrose P. Boyle, W. Kenneth Clark, Joseph J. Geller, George C. Peck, Daniel Roth, Ben Sheiner, Bruce Y. Tapper, James J. Vanderbeck, Florence Wax-Schlam.

ELECTION TO MEMBERSHIP

To Regular by transfer—James J. Vanderbeck (from Passaic County Medical Society). *To Regular from Associate* (effective July 1, 1960)—Ambrose P. Boyle, Robert T. Miller, Guillermo J. Munoz, George C. Peck, Bruce Y. Tapper. *To Associate* (effective July 1, 1960)—William H. Bristow, Jr., Frank Colantuono, Ronaldo DeAndrade, Nejat Huseyin, Sheldon N. Feinberg, Victor S. Garra, Michael R. Loreti, Lawrence J. Mazzei, Earl A. Wheaton, Jr., Noyes E. Yale, Jr.

It was moved, seconded and carried that the Secretary be instructed to cast one ballot for the election of these doctors.

Dr. Verdon presented the second reading of the following resolution which was read at the May Annual Meeting:

Be It Resolved that Article V, Section 2 paragraph 2 be amended as follows:

Delete the second sentence and insert it after the sentence—"Elections shall be held at the next Regular Meeting following the nominations."

On motion seconded and passed, the resolution was adopted.

Dr. Helden presented a resolution on contract plan laboratory services. On motion seconded and passed, the resolution was laid on the table.

Dr. Hull expressed appreciation for the close cooperation granted him during his tenure of office by the officers and committees with whom he worked during the past year. He thanked Mr. Fincke, Executive Secretary with the remark "With whom I could not do without." He expressed appreciation to Mrs. Hughes, Assistant Secretary, and Mrs. Sanford, Bookkeeper, for efficient services during the year.

Dr. Hull then installed the following officers and asked each to rise to acknowledge his introduction and title: Alfred A. Alessi—Assistant Treasurer, John P. O'Connor—Treasurer, Charles P. Campbell—Secretary and Reporter, Samuel B. Reich—2nd Vice-President, Walter Wahrenberger—1st Vice-President, and George O. Rowohlt—President.

In handing the gavel to Dr. Rowohlt, Dr. Hull expressed his feeling of confidence in Dr. Rowohlt as President of our Society. Upon accepting the gavel, Dr. Rowohlt pointed out a few of the projects and problems confronting the Society.

Dr. Rowohlt presented to Dr. Hull a plaque expressing the appreciation of the members of the Society for his leadership as President during the past year.

The meeting adjourned to an excellent steak dinner. Mr. Sal DeLuisa entertained on his electric accordion during dinner.

CHARLES P. CAMPBELL, M.D.

Reporter

Cumberland

The June meeting of the *Cumberland County Medical Society* was held on June 14 at Palatine Lake. The Society was the guest of the Owens-Illinois Glass Company. Dr. Benjamin Berkowitz presided. There were 45 members present.

Joseph Dortch, M.D., of Vineland and Frank Pocaro, M.D., of Vineland were elected to Active membership in the Society.

Calvin Hahn, M.D., of Vineland was approved as the county's selection to serve on the State Maternal Welfare Committee.

Annual committee reports were given.

The Society was pleased to have as its guests: Renee Zindwer, M.D., Chief of the Maternal and Child Health Department of the State Department of Health, and Hugh D. Palmer, M.D., the South Jersey representative of the State Department of Health. Dr. Zindwer gave a resume of the functions of her committee when dealing with such problems as poison control services, accidental poisoning in children, the diarrheal problem, the staph infection problem, mental retardation, the psychiatric aspect of pediatrics and preventive medicine; Mrs. Edith Madden, Administrative Secretary to The Medical Society of New Jersey, with her staff, Mrs. Walton and Mrs. Stockton.

The meeting was highlighted by unanimous adoption of a Resolution, inscribed in the minutes, acknowledging the 23 years of untiring service rendered by Mary Bacon, M.D., as Secretary of the Society. Amid acclamation, a silver tray was presented to Dr. Bacon for her achievement. The resolution appears on page 500.

A delicious charcoal steak and lobster dinner was served to the members of the Society and their wives in the open spaces of the Onized Cabin, much to the delight of all.

LEONARD G. SCOTT, M.D.

Reporter

Union

The regular meeting of the *Union County Medical Society* was held on May 11 at White Laboratories, Kenilworth, with Dr. Carl G. Kapp, the president, in the chair. Dr. William L. Rumsey, Jr., introduced the speakers of the evening: Miss Mary C. Woodward, Executive Secretary of the Family and Children's Society and Mr. Theodore A. Rathjen, Welfare Director of Elizabeth.

Miss Woodward discussed adoption procedures. Mr. Rathjen told of the welfare services available.

The following were elected to Associate membership in the society: Drs. Victor D'Ambrosio and John Donahue of Elizabeth, Philip Gatto of Rahway, George Truchly of Westfield, and Nancy Davis of Plainfield.

Elected to full membership after fulfilling the duties of Associate membership for two years were: Drs. R. M. Renzulli of Elizabeth, and Jerome Abrams, Ovid Santoro and G. V. Schoenbrun of Plainfield.

Transferred to membership in the Union County Medical Society were Drs. Edward McMahon of Union, formerly of Ocean County; William Rowe of Linden, formerly of New York County and John L. Tullis of Summit, a former member of the Charles River District Medical Society, Massachusetts.

HENRY J. MINEUR, M.D.

Reporter

Book Reviews • • •

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Pain and Itch. Edited by G. E. Wolstenholme, M.B. and Maeve O'Connor, B.A. Boston, 1959. Little, Brown and Company. Pp. 120 with 41 illustrations. A Ciba Foundation Study. ($2.50)

These eight lectures concern studies of the conduction rates and electric changes induced by the transmission of nerve impulses in animals. They deal almost exclusively with the unmyelinated C fibers, which terminate in arborizing free nerve endings thus acting as cutaneous receptors for thermal, mechanical and noxious stimuli which give rise to sensations of itch and pain.

The effects of pruritogenic substances on these neuroreceptors, especially the proteases is discussed. The proteases trypsin and papain were used as prototypes. Trypsin acts by liberating histamine and produces wheals accompanied by itch. Papain produces itch without the liberation of histamine or wheal formation and this type of pruritis (*i.e.*, without obvious skin changes) is more common clinically. Some unmyelinated fibers transmit other modalities (touch) as well as pain and itch.

In studies of the mechanisms of pain in trigeminal neuralgia the trigger zones of the face and lips are outlined. The most adequate stimulus for triggering paroxysms of pain is light touch. Shaving, washing the face or mastication also initiate paroxysms. Conversely, thermal stimuli, deep pressure or pain (pinching skin of trigger zone with a for-

ceps) failed to elicit a response. The evidence that pain producing impulses must travel over the C fibers exclusively is by no means proved.

The impression drawn from these experiments is that sensory receptors may respond to more than one form of energy or subserve more than one modality. The early hope that the successful recording of impulses in cutaneous nerves would quickly resolve many problems connected with pain has not been realized. Instead, the problem becomes more complex; and in the future, we may be less prone to ascribe exclusive, specific sensory functions to a particular group of nerve fibers.

If the booklet is perused carefully, keeping in mind phylogenetic development and purposes nature is attempting to achieve, one can derive some intellectual pleasure in trying to correlate some of these apparently contradictory results. There must still be a relationship between design and function.

JOSEPH E. HIGI, M.D.

Mental Subnormality: Biologic, Psychologic and Cultural Factors. By Richard Masland, M.D., Seymour Sarason, Ph.D. and Thomas Gladwin, Ph.D. New York, 1959. Basic Books. Pp. 442. Ed. 3. ($6.75)

For a comprehensive view of mental deficiency and mental retardation, this work by a physician, a psychologist and an anthropologist provides the richest lode yet found in one volume. Most of the important research in this area is here cited, discussed, and keenly criticized. Most important to the researcher is the posing of new questions arising out of current research. The authors are flexible, however, and are more concerned with presenting problems to encourage further research than in demanding that they fit any established theoretical position.

The first section, by a physician, discusses the current state of our biologic knowledge about the subnormal child. Dr. Masland acknowleges that biologic factors cannot be separated from the psychologic and cultural ones; but for purposes of investigation it is necessary to separate the variables. For the physician, the biochemist and the neurologist, there is presented concisely and very readably a mounting number of questions to be studied, both in the laboratory and in the field.

The intimate relation between these organic factors and those of psychologic and cultural origin is well treated in the second and major part of the book. Dr. Sarason and Dr. Gladwin use the kind of highly individual, yet "team-oriented" thinking that is so urgently needed in the study of human behavior. By "team-oriented," I mean the ability to achieve a broad concept of the problem, concentrating on one's own discipline, yet never losing sight of the contributions of other fields and their relevancy to the whole problem.

Crucial to the investigation of mental subnormality is the differentiation between the severely defective child (in which the presence of central nervous system pathology is clearly demonstrable) and the higher grade of mental defect, the mentally retarded child, where psychologic and cultural factors are more evidently responsible. "How" these factors operate is still to be more precisely formulated. New tools must be devised before solutions can be approached. The study of psychoses in subnormals and the relationship between the idiot savant and the autistic child are two specific areas of interest which have been given extensive discussion. The implications of these studies for a further understanding of normal learning and of mental disease are thoroughly explored.

Mental subnormality interests the teacher, the physician, the psychologist, and the social scientist. This work should be enthusiastically received by all four since the opportunities to work in each field are pointed out as being most important to the understanding of the people of all races and of all cultures who are unable to get along because of inadequate intellectual functioning.

LILLIAN L. WEINBERGER, M.A.

Medically Important Mosquitoes. By R. R. Foote and D. R. Cook. U. S. Department of Agriculture, Washington, D. C., 1959. Pp. 158. Gratis.

This handbook will enable the entomologist to identify mosquitoes in any part of the world. It is illustrated by 65 "pictorial keys" which make it possible for even a minimally-trained observer to identify the medically important mosquito. The book represents a joint venture between our military services, our medical services and the Department of Agriculture.

HENRY A. DAVIDSON, M.D.

Synopsis of Ear, Nose and Throat Diseases. R. E. Ryan, M.D., W. C. Tornell, M.D. and Hans Von Leden, M.D. St. Louis, 1959. Mosby. Pp. 383. ($6.75)

Synopsis of Ophthalmology. W. H. Havener, M.D. St. Louis, 1959. Mosby. Pp. 288. ($6.75)

Every general practitioner is faced with the problem of building a working library of the major specialties without cluttering his shelves with over-specialized works. Books like these two *Synopses* are tailor-made for this purpose. Considering their small size, they may ssem to be overpriced,

but each book is well illustrated and ruggedly bound. The EENT book reviews the common disorders of the ear, nose, sinuses, larynx and pharynx. There is excellent and compact coverage of applied anatomy and basic physiology and the treatment suggestions are practical and forthright.

The ophthalmology text covers glaucoma, strabismus, conjunctivitis and the other common ophthalmic disorders. Dr. Havener includes an excellent chapter on ocular therapy, which is offered in case study fashion. There are also good chapters on eye injury and on ocular examinations.

The books admirably serve their purposes as up-to-date usable guides for the well-rounded general practitioner.

ULYSSES M. FRANK, M.D.

Babies by Choice or by Chance. Alan F. Gutmacher, M.D. Garden City, New York, 1959. Doubleday. Pp. 289. ($3.95)

Intended for the intelligent layman, this book reviews birth control methods and discusses the medical, legal, moral and social aspects of abortion, sterilization, artificial insemination and contraception. The author is chairman of the medical committee of the Planned Parenthood Federation and his views on these subjects may be anticipated. In spite of a strong polemical flavor, the basic facts are presented with reasonable objectivity. The conclusions and interpretations are, of course, subject to dispute. Indeed, the author himself opens Chapter One with this sentence: "This is an indignant book!" Dr. Gutmacher explains that he is "indignant that the liberal side of the socio-medical issues we discuss is rarely, if ever, portrayed to the American reader by a physician." He sets out to fill that gap, and does so with vigor and eloquence.

VICTOR HUBERMAN, M.D.

The Management of Fractures and Dislocations; An Atlas. By Anthony F. DePalma, M.D. Philadelphia, 1959. Saunders. 2 Vols. ($35.00, set of 2 vols.)

From start to finish, this is a thoroughly and readily useable book for orthopedist, surgeon and house officer. Each fracture is treated graphically. The important characteristics and detailed methods of treatment are clear and orderly. Everything pertinent has been included. Dr. De Palma has emphasized methods of treatment which have yielded the best results in his own hands. While there may be reasonable grounds for disagreement, the qualified author should be partisan in emphasizing his own methods. The discussion and treatment of complications are excellent. The general format, drawings and concise expression cannot be too highly praised.

PETER J. GUTHORN, M.D.

Viral Hepatitis. H. F. Eichenwald, M.D. and J. W. Mosley, M.D. U. S. Public Health Service Communicable Disease Center, Atlanta, Ga., 1959. Pp. 56. Paper. ($0.20)

For twenty cents you can get this modest brochure which packs into its 56 pages a surprising amount of information about hepatitis. It covers diagnosis and treatment, and tells how to operate a mass inoculation clinic. There is also some unique material on the epidemiology of the disease. This is U. S. Public Health Service Publication 435 and is obtainable from the U. S. Government Printing Office in Washington under that designation.

ULYSSES M. FRANK, M.D.

When a Family Faces Cancer. By Elizabeth Ogg. Public Affairs Pamphlet 286. Published 1959 by the Public Affairs Committee at 22 East 38 St., New York City. ($0.25)

This brochure suggests ways of handling the situation created by a relative's cancer. It discusses preparation for surgery and for rehabilitation. It suggests how to detect a quack. It encourages the building up of a good relationship with the M.D. It weighs the emotional problems produced in the family by the knowledge of a loved one's malignancy. It is a warm, sound booklet that may prove a blessing to certain families. At the modest cost of 25 cents, it is something that any doctor can give to families of cancer patients.

ABRAHAM LEFF, M.D.

Handbook of Poisoning. By Robert H. Dreisbach, M.D. Los Altos, California, 1959. Lange Medical Publications. Ed. 2. Pp. 475. ($3.50)

The inside front cover of this volume contains space for emergency phone numbers and a list of first-aid measures. The inside back cover carries a check list of household poisons. Between the end

pages are 37 chapters covering nearly all possible poisons with concise spelling out of symptoms and treatment. There is a chapter on resuscitation equipment and another on legal responsibilities in the treatment of poisoning. The book is 4 by 7 by ¾ inches and can easily be kept in the doctor's bag or even in an overcoat pocket. It may well save someone's life.

HENRY A. DAVIDSON, M.D.

Cancer: Worldwide Menace. Prepared for the U. S. Senate Committee on Government Operations. Paper. Washington 25, D. C. Government Printing Office. 1959. Pp. 40. ($0.40)

Packing a vast amount of correct information into a small space, this pamphlet gives the layman an honest, understandable and hopeful picture of cancer. It is illustrated with vivid graphs and maps. Written for the general reader, it is arranged as a catechism with the 31 commonest questions asked about cancer and their answers in the light of present knowledge. It retails at a modest 40 cents a copy.

VICTOR HUBERMAN, M.D.

The Reluctant Surgeon: A Biography of John Hunter. By John Kobler. New York, 1960. Doubleday. Pp. 359. ($4.95)

This fine biography of Dr. John Hunter (1728-1793) provides an accurate and readable account of the life, labors and times of the dour Scot who was, in the words on his memorial in Westminster Abbey, "the founder of scientific surgery." Surgeon to King George III, naturalist, experimenter and collector, Hunter lived in a fascinating age—and was a bright ornament of the period. An unusual person of genius, his industry did much to turn surgery and pathology into sciences. In this book, *Saturday Evening Post* editor John Kobler achieves his stated goal, "to reclaim the scientist from the archives and the man from the shadows."

John Hunter and his older brother William, both fine anatomists, were pioneers in study of the lymphatics, generation and parturition. Experimental surgery owes much to John Hunter for his methodical research on inflammation, repair and tissue transplants. His achievements in biology, comparative anatomy, dentistry, hematology and urology, ranged far and wide in scope. Students and disciples of "the dear man" included Edward Jenner—English discoverer of vaccination against smallpox, John Morgan—founder of North America's first medical school, and his Philadelphia colleague, William Shippen, Jr., Philip Syng Physick—the "father of American Surgery," and Benjamin Waterhouse—Harvard professor and early vaccinator in the United States. (Through the office of his friend, Benjamin Franklin, John Hunter was elected a member of the American Philosophical Society in 1787.)

John Hunter's brilliant contributions to medicine, his turbulent life, colorful personality, and the setting in which he prospered, are all deftly recreated in this new biography. Although lacking illustrations, the volume has adequate notes, a detailed bibliography and an index. It is highly recommended to all who would know more about an heroic figure in the history of medicine.

FRED B. ROGERS, M.D.

Modern Nutrition in Health and Disease. Edited by Michael G. Wohl, M.D. and Robert S. Goodhart, M.D. Philadelphia, 1960. Lea & Febiger. Pp. 1152, with 75 illustrations and 154 tables. ($18.50)

Nutrition has become a popular subject and so much has occurred in the last five years as to make necessary a second edition of this book. This compilation is an excellent series of monographs written by reliable authorities. Many of the contributors have exhaustively canvassed the current literature, thus saving the reader a considerable amount of time. This is especially true in the sections on the physiology of the gastro-intestinal tract, the psychology of appetite, fluid and electrolyte balance, chemical and other additives, criteria of an adequate diet, diet in diabetes and nutrition in relation to atherosclerosis.

On the other hand, chapters dealing with dietary interrelationships, obesity, and undernutrition are woefully inadequate both in content and in bibliography. In the interest of objectivity, the subjects should have received more emphasis.

This book as a whole represents a unified approach to the problem of nutrition in health and disease. It is as good a reference as we have to date on this subject. Doctors Wohl and Goodhart are to be congratulated for bringing nutrition into everyday medicine.

S. WILLIAM KALB, M.D.

WHY *ALDACTONE*®

IN EDEMA

Because it acts by regulating a basic physiologic imbalance, Aldactone possesses multiple therapeutic advantages in treating edema.

Aldactone inactivates a crucial mechanism producing and maintaining edema — the effect of excessive activity of the potent salt-retaining hormone, aldosterone. This corrective action produces a satisfactory relief of edema even in conditions wholly or partially refractory to other drugs.

Also, Aldactone acts in a different manner and at a different site in the renal tubules than other drugs. This difference in action permits a true synergism with mercurial and thiazide diuretics, supplementing and potentiating their beneficial effects.

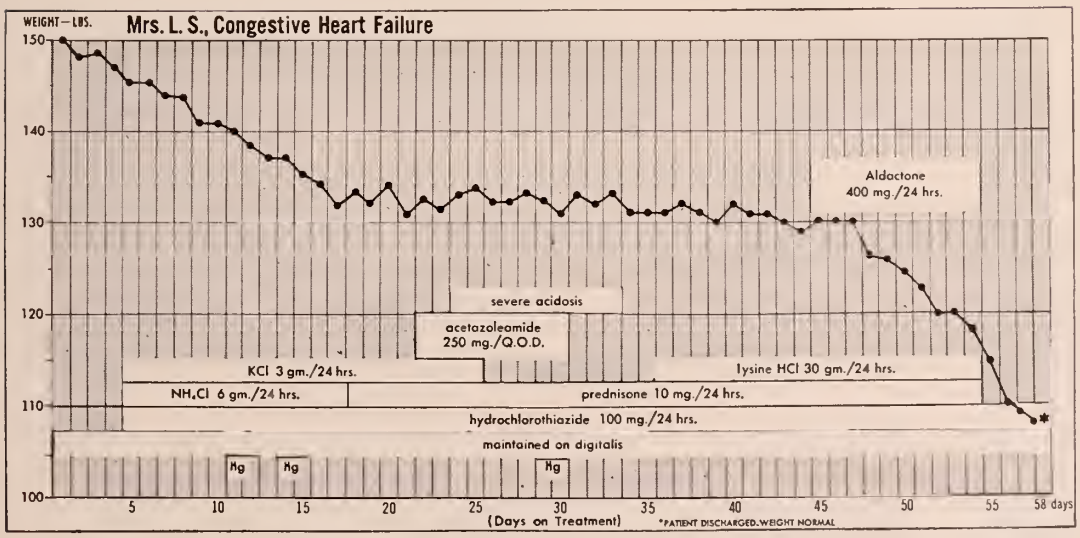
Further, Aldactone minimizes the electrolyte upheaval often caused by mercurial and thiazide compounds.

The accompanying graph shows a dramatic but by no means unusual instance of the effect of Aldactone in refractory edema.

The usual adult dosage of Aldactone, brand of spironolactone, is 400 mg. daily. Complete dosage information is contained in Searle New Product Brochure No. 52.

SUPPLIED: Aldactone is supplied as compression-coated yellow tablets of 100 mg.

G. D. SEARLE & CO., Chicago 80, Illinois.
Research in the Service of Medicine.



massages pain away in musculoskeletal involvements[1]

GER-O-FOAM

(aerosol foam)

relieves pain, spasm; improves function increases tolerance to exercise

GER-O-FOAM's exclusive formula provides for the first time deeply absorbed analgesic-anesthetic agents in aerosol form — to permeate and anesthetize sensory nerve endings.

Relief in minutes, lasting for hours in . . . rheumatoid arthritis, osteoarthritis, muscle sprain, fibromyositis, low back pain . . . even in chronic intractable cases.

GER-O-FOAM combines: Methyl salicylate 30%, benzocaine 3%, in a neutralized emulsion base, permitting fast penetration through the stratum corneum.

Sample and reprint from

GERIATRIC PHARMACEUTICAL CORP.
Bellerose, New York

Pioneers in Geriatric Research

1. Gordon, E. E. and Haas, A.: Industrial Medicine & Surgery 28:217, 1959.

GERIATRIC

Include MILK *in your* LOW-SALT DIETS

It's no longer necessary to deny patients fresh, fluid palatable Milk in low-salt diets. Walker-Gordon fresh Lo-Sodium Milk (Certified Milk with 90% of Sodium removed) contains less than 50 mg. Sodium per quart. *Guaranteed free of Penicillin.* Paper half-pints for hospitals, quart bottles for home delivery. Write or phone for literature, low-sodium diet sheets, and professional sample.

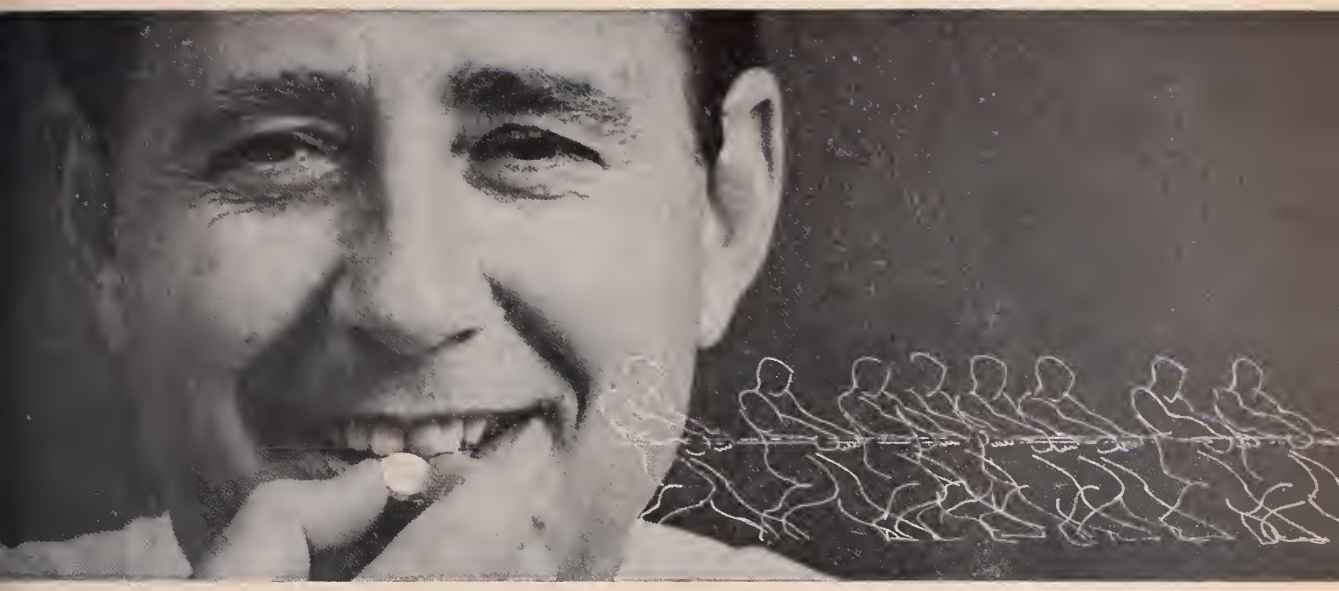
WALKER-GORDON *Fresh* LO-SODIUM MILK

Walker-Gordon Certified Milk Farm, Plainsboro, N.J. ★ SWinburne 9-1234

New York: WAlker 5-7300 ★ Phila.: LOcust 7-2665

Also Certified Raw, Pasteurized, Homogenized-Vit. D, Skimmed Milks and Acidophilus; available through leading Milk Dealers or call Walker-Gordon

in antacid therapy...
patient cooperation is half the battle



Are you chancing unsatisfactory results because the patient doesn't like the taste of the antacid you have prescribed? Assure patient cooperation. Prescribe the antacid which assures patient acceptance through its excellent palatability.

Palatable

'Margel'

unsurpassed in performance
unequalled in palatability

antacid suspension/tablets

MARGEL is a highly palatable formulation of four antacids: selected aluminum hydroxides, magnesium hydroxide, magnesium trisilicate and calcium carbonate. Balanced to be non-constipating; formulated to be non-chalky. Write for a sample and see for yourself.

Supplied: Margel Suspension — bottles of 12 fluid ounces. Margel Tablets — boxes of 96.
Dosage: SUSPENSION: 1 tablespoonful 20 minutes after meals and on retiring. May be taken with milk if desired. TABLETS: 2 or more tablets 20 minutes after meals and on retiring. May be chewed or allowed to dissolve slowly in the mouth.

MRT *M. R. Thompson, Inc.* CRANFORD, N. J.

CLASSIFIED ADVERTISEMENTS

WANTS FOR SALE TO LET

SITUATIONS ETC.

Send replies to box number c/o **The Journal** P. O. Box 904, Trenton 5, N. J.
$3.00 for 25 words or less: additional words 5c each Forms close 15th of the Preceding Month.

GENERAL PRACTITIONER—Wishes to relo ate and desires to buy, lease, general practice or go into association. Write Box PD, c/o THE JOURNAL.

QUALIFIED OR BOARD ELIGIBLE PSYCHIATRIST—for private active treatment unit. Many community attractions. Opportunity for seminars and analysis. Liberal benefits and future opportunity. *Write*: V. Gerard Ryan, Elmcrest Manor, Portland, Connecticut.

GENERAL PRACTITIONER WANTED—Partnership of two young men in rapidly growing general practice need a third physician to join them. Located in new medical-center type offices in South Jersey only fifteen miles from Philadelphia. Please send full details. Write Box ST, c/o THE JOURNAL.

ASSISTANT TO MEDICAL DIRECTOR—for 280-bed County, accredited Hospital. Requirements, experience in Chest Diseases, Internal Medicine (Geriatrics); New Jersey State license. Modern furnished accommodation and full maintenance at nominal cost; excellent pension plan combined with Social Security, also free hospitalization, paid vacation, sick leave and holidays. Salary depending on experience and qualifications. Contact Eugene Nargiello, M.D., Superintendent and Medical Director, John E. Runnells Hospital for Chest Diseases, Berkeley Heights, New Jersey.

SENIOR PHYSICIAN—for 280-bed County, accredited Hospital. Requirements, approved internship and training in Chest Diseases, experience in Internal Medicine (Geriatrics); eligible for license in New Jersey or licensed in any State. Modern furnished accommodation and full maintenance at nominal cost; excellent pension plan combined with Social Security, also free hospitalization, paid vacation, sick leave and holidays. Salary depending on training and experience. Contact Eugene Nargiello, M.D., Superintendent and Medical Director, John E. Runnells Hospital for Chest Diseases, Berkeley Heights, New Jersey.

RUTHERFORD, N. J.—5 rm. office, Pvt. street entrance. Centrally located luxury elevator building. Suitable MD or DDS. Available for immediate occupancy. Briar Hall Apts., 130 Orient Way, GEneva 8-6700 or WEbster 9-3139.

PLAINFIELD, N. J., 1310 West 7th St.—Two suites available, newly built professional building. Wood panelled waiting room, nurses' station, 3 examination rooms one suite, and 2 examination rooms the other suite. Private lavatories, central heating and air conditioning, on site parking. Rent reasonable. Call WAverly 6-3238. One suite now occupied by dentist.

ULTRAMODERN PROFESSIONAL BUILDING—Air-conditioning, adequate parking facilities, being erected at 588 Eagle Rock Ave. in rapidly growing section of Pleasantdale, West Orange, N. J. Occupancy planned in Winter, 1960. Write or call ORange 2-9195.

UNUSUAL OPPORTUNITY—Professional Bldg., Montclair, New Jersey. Every advantage. Very low rental. Dr. Mearin—PI 4-5657.

MEDICAL ARTS BUILDING OF JERSEY CITY—8-12 Clifton Place, Jersey City, N. J. Suites available—for professional use only—air-conditioned building. For information call DElaware 3-7573. Brochure upon request.

EDISON, N. J.—Stelton Section. Entire 5 room house for rent. Busy corner on main street. Ideal for OB or PED. Parking. KIlmer 5-5083.

NEW, AIR-CONDITIONED, FIRST FLOOR OFFICE AVAILABLE—with parking facilities; flexible room arrangement; desirable Madison location, near hospital, shopping center and bus lines. Call HU. 2-3443 or FR. 7-7746.

NEW MEDICAL SUITES AVAILABLE in excellent location; at line of Hudson & Bergen Counties. One-story building with parking; all modern conveniences supplied. $160-$175/mos. Bergenline Professional Bldg., 8609 Bergenline Ave., North Bergen, N. J. UN. 9-0850.

IN MONTCLAIR—2 or 3 large rooms, ideal location, air-conditioned. Separate entrance. Parking facilities. PI. 4-2030.

MONTCLAIR—Second floor of attractive corner property, excellent location, air-conditioned. Separate entrance. Parking. PI. 4-2030.

(Continued on following page)

CLASSIFIED ADVERTISEMENTS

(Continued from preceding page)

ROSELLE—Physician's offices: waiting room, 2 treatment, 2 consultation, x-ray, laboratory. One block to business center and all transportation. Call CHestnut 5-7928 between 5 and 7.

FOR SALE—Corner property best section of Park St., Upper Montclair. 12 rooms, 4 baths, powder room, attached 3 room office with separate entrance. House all redecorated. 2 car garage. Price $36,500. Call PI 4-8358.

FOR SALE—In Bridgeton, N. J. House including offices of the late Dr. Charles Fromkin. House includes lovely living room, large center hall, large dining room, kitchen, and pantry. Upstairs, three large bedrooms and bath. The offices include waiting room, consultation room, examining room, and lavatory. For information contact Mrs. Charles Fromkin, 20 Bank St., Bridgeton, N. J. Telephone: BRidgeton 9-1483.

FOR SALE—Haddonfield, N. J. Practice, general and specialty of metabolic obesity. Street level office suite, centrally located; bus lines and parking available. Rented suite includes modernistic reception and consultation rooms; examination-surgical room; large reducing salon, fully equipped; dressing room; two lavatories; receptionist office. Complete records. Will introduce one month. Moving to West. For further information call HAzel 9-1214 or write Box ES, c/o THE JOURNAL.

DOCTOR'S HOME FOR SALE—Large attractive corner lot in residential Metuchen, New Jersey. Custom built. Includes 4 room office, 5 bedrooms, 3½ baths, living and dining rooms, large kitchen, and two-car garage in rear. Within 5 mile radius of 4 hospitals. Address: 82 Spring Street, Metuchen, New Jersey. Or call LIberty 9-1764.

THE ORANGE PUBLISHING CO.

PRINTERS

•

116-118 Lincoln Avenue
Orange, N. J.

CARDIOLOGY
Postgraduate Course

HAHNEMANN MEDICAL COLLEGE and HOSPITAL

THURSDAYS 1:30 to 3:30 P.M.

30 Sessions October through May

This course is divided into three sections dealing with three important phases of Cardiology, designed especially for the General Practitioner.

Section 1. Electrocardiography (30 Hours)
Section 2. Cardiac Auscultation (20 Hours)
Section 3. Special Graphic Methods in Heart Disease (10 Hours)

The sections of the course may be taken individually or as a group. Acceptable as Category I credit for AAGP postgraduate education requirements.

Detailed information forwarded on request to:

LOWELL L. LANE, M.D.
CARDIOVASCULAR SECTION
HAHNEMANN HOSPITAL
PHILADELPHIA 2, PENNA.

A LOGICAL ADJUNCT TO THE WEIGHT-REDUCING REGIMEN

meprobamate **plus** d-amphetamine... reduces appetite...elevates mood...eases tensions of dieting...**without** overstimulation, insomnia or barbiturate hangover.

Dosage: One tablet one-half to one hour before each meal.

anorectic-ataractic

BAMADEX®

meprobamate 400 mg., with d-amphetamine sulfate 5 mg., Tablets

Lederle

For All Non-Psychiatric Physicians . . .

1960 POSTGRADUATE COURSE IN PSYCHOSOMATIC MEDICINE

- **Presented by an Experienced and expert faculty from the Departments of Psychiatry, Internal Medicine and Obstetrics and Gynecology of the TEMPLE UNIVERSITY MEDICAL CENTER.**

  The outstanding feature of this Course is that **each member diagnoses and treats his own psychosomatic case under close, expert supervision, instruction and control.** This is an unparalleled opportunity which more than justifies the entire time spent. In addition, there are lectures, live-case presentations, and discussions of the various psychosomatic problems.

- Course is held each Wednesday for 20 weeks, beginning on October 5, 1960 from 10:00 a.m. to 3 p.m. **It is approved by A.A.G.P. for 80 hours of Category I credit.**

WRITE FOR BROCHURE AND APPLICATION BLANK TO:

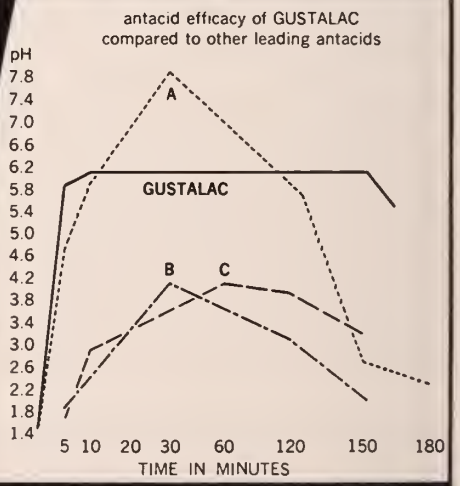
H. KEITH FISCHER, M.D., Director
Postgraduate Course in Psychosomatic Medicine
100 W. Coulter Street Philadelphia 44, Pa.

patients welcome the pleasant way

GUSTALAC

TABLETS

give immediate relief from
Gastric and Duodenal ULCERS
HYPERACIDITY
Heartburn of Pregnancy



Each dose eases pain, "burning" and eructation for 2½ hours — two tablets are equal in buffering value to 10 oz. of milk. Does not cause acid rebound, constipation or systemic alkalosis.

PLEASANT TASTING GUSTALAC tablets each provide: the "most potent antacid,"[1] superfine calcium carbonate (300 mg.), buffer-enhanced by a special high protein defatted milk powder (200 mg.).

DOSAGE: 2 tablets chewed or swallowed q. 2 to 3 h. PRN and on retiring.

1. Kirstner, J. B.: J.A.M.A. 166:1727, 1958.

Samples **and literature on request**

GERIATRIC PHARMACEUTICAL CORPORATION
Bellerose, N. Y.

Pioneers in Geriatric Research

anorectic-ataractic ®

BAMADEX

meprobamate 400 mg., with d-amphetamine sulfate 5 mg., Tablets

FOR THERAPY OF OVERWEIGHT PATIENTS

- d-amphetamine depresses appetite and elevates mood
- meprobamate eases tensions of dieting (yet without overstimulation, insomnia or barbiturate hangover).

Dosage: One tablet one-half to one hour before each meal.

A LOGICAL COMBINATION IN APPETITE CONTROL

Lederle

Protection against loss of income from accident and sickness as well as hospital expense benefits for you and all your eligible dependents.

PHYSICIANS CASUALTY & HEALTH ASSOCIATIONS

OMAHA 31, NEBRASKA

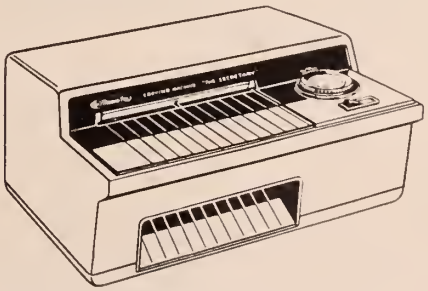
ALL PREMIUMS COME FROM — PHYSICIANS SURGEONS DENTISTS — ALL BENEFITS GO TO

Since 1902
Handsome Professional Appointment Book sent to you FREE upon request.

PROMPT BILLING MEANS PROMPT PAYMENT with the THERMO-FAX COPYING MACHINE

Thermo-Fax®
COPYING PRODUCTS

You can now handle your month's billing in a single morning. Give patients an accurate, comprehensive picture of their medical expenses by copying statements from each patient's ledger record. In just 4 seconds, the **THERMO-FAX** all-electric process gives you clean, dry, permanent copies ready for mailing. And **THERMO-FAX** saves time and money on copies of insurance medical claim forms, prescriptions, supply lists, reports, special diets, and correspondence. Fill in and mail the enclosed coupon for additional information on **THERMO-FAX**—the copying machine that costs pennies to operate and saves you dollars.



Thermo-Fax Sales, Inc.
Dept. M60
33 Lincoln Park
Newark, New Jersey Mitchell 2-1450

3M COMPANY

I am interested in the THERMO-FAX Copying Machine. Please have your representative call me for a demonstration at no obligation.

NAME .....
ADDRESS ..... PHONE .....
CITY ..... STATE .....

The Children's Country Home

An accredited 54-bed specialized hospital for handicapped children. Especially equipped for care of cardiac pre- and postoperative cases, cerebral palsy, polio, congenital defects, rheumatoid arthritis, Legg-Perthes' diseases and other orthopedic conditions. Our services include physical therapy and pool treatments, x-ray, occupational and speech therapy. Regular schooling is provided.
The referring physician may continue to prescribe treatment or may transfer responsibility to our staff.

* * *

New Providence Road
Westfield, New Jersey

PHONE
CH. 2-2330

for well trained highly qualified personnel

MEDICAL
OFFICE ASSISTANTS OR SECRETARIES

Co-Ed (Founded 1936)
N. Y. State Licensed Day-Eve. Courses
Trained by Physicians for Physicians

Eastern *request Free Cat. 7*

SCHOOL FOR PHYSICIANS' AIDES
85 Fifth Ave. (16th St.) New York 3, N. Y.
affiliated with CARNEGIE INSTITUTE. INC. *Cleveland, O.*

The Glenwood Sanitarium

LICENSED FOR THE CARE AND TREATMENT OF
NERVOUS AND MENTAL DISORDERS
ALCOHOLISM AND DRUG ADDICTION

Homelike surroundings, good nursing psychiatric treatment, including shock therapy and excellent food.

R. GRANT BARRY, M.D.

2301 NOTTINGHAM WAY TRENTON, N. J.
JUniper 7-1210

BAMADEX®

meprobamate 400 mg., with d-amphetamine sulfate 5 mg., Tablets

A logical combination for appetite suppression

meprobamate **plus** d-amphetamine...suppresses appetite...elevates mood... reduces tension...**without** insomnia, overstimulation or barbiturate hangover.

anorectic-ataractic

Dosage: One tablet one-half to one hour before each meal.

Lederle

Dugan's
"Bakers for the Home"

New - LITE DIET BREAD

(White Bread Baked Without Shortening)
Calories per Slice 42 Calories per Oz. 70

ALSO

SALT-FREE BREAD
GLUTEN AND PROTEIN BREADS
100% WHOLE WHEAT
100% Whole Wheat Crackers

New York New Jersey
Connecticut Pennsylvania

"AT YOUR DOOR OR TO YOUR STORE, IT'S DUGAN'S FOR BETTER BAKED GOODS"

Phone for Delivery

HUmboldt 2-6007 in Newark

(or your local phone book for branch nearest you)

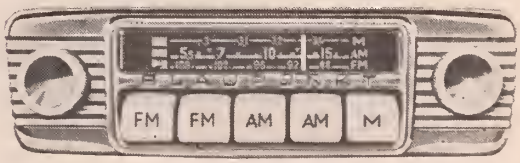
NOW! ASTOUNDING*

in your car

Enjoy the Blaupunkt FM/AM car radio—The world's finest Hi-Fi in motion...Brilliant tone—amazing sensitivity—pin point selectivity—plus uninterrupted reception...no fade-out on bridges, no blackout in underpasses.

FREE! WIN TRIP TO EUROPE FOR 2, via LUFTHANSA Boeing Jet Intercontinental plus 19 other prizes. Nothing to buy or think up. Just visit your dealer for a demonstration of "FM in motion"!

Finest across the Atlantic
LUFTHANSA
GERMAN AIRLINES



BLAUPUNKT

TRANSISTORIZED SYMBOL OF QUALITY

FM / AM and AM CAR RADIOS

Blaupunkt® REG. U.S. PAT. OFF. BLAUPUNKT-WERKE GMBH HILDESHEIM - GERMANY. A SUBSIDIARY OF ROBT. BOSCH G.M.B.H.

hi-fi IN MOTION

***FOR FREE ENTRY BLANK**—and reprint of informative, exciting article from Electrical Industries Magazine on "ASTOUNDING FM reception"—**MAIL COUPON BELOW**

Robert Bosch Corp., Blaupunkt Car Radio Division
Dept. MJ2 40-25 Crescent St., L. I. City, 1, N.Y.
or 225 Seventh Street, San Francisco, California

Gentlemen: Please send me free entry blank and reprint mentioned above.

NAME.....

ADDRESS.....

CITY.....ZONE.....STATE.....

Proven

in over five years of clinical use and more than 750 published clinical studies

Effective

for relief of anxiety and tension

Outstandingly Safe

- simple dosage schedule produces rapid, reliable tranquilization without unpredictable excitation
- no cumulative effects, thus no need for difficult dosage readjustments
- does not produce ataxia, change in appetite or libido
- does not produce depression, Parkinson-like symptoms, jaundice or agranulocytosis
- does not impair mental efficiency or normal behavior

for the tense and nervous patient

Despite the introduction in recent years of "new and different" tranquilizers, Miltown continues, quietly and steadfastly, to gain in acceptance. Generically and under the various brand names by which it is distributed, meprobamate (Miltown) is prescribed by the medical profession more than any other tranquilizer in the world.

The reasons are not hard to find. Miltown is a *known* drug, evaluated in more than 750 published clinical reports. Its few side effects have been fully reported; there are no surprises in store for either the patient or the physician. It can be relied upon to calm anxiety and tension quickly and predictably.

Usual dosage: One or two 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets; or as MEPROTABS*—400 mg. *unmarked,* coated tablets.

*TRADE-MARK

Miltown®

meprobamate (Wallace)

WALLACE LABORATORIES / *New Brunswick, N. J.*

CM-2053

"Gratifying" relief from

for your patients with
'low back syndrome' and
other musculoskeletal disorders

POTENT muscle relaxation
EFFECTIVE pain relief
SAFE for prolonged use

stiffness and pain

"gratifying" *relief from stiffness and pain in 106-patient controlled study (as reported in J.A.M.A., April 30, 1960)*

"Particularly gratifying was the drug's [SOMA's] ability to relax muscular spasm, relieve pain, and restore normal movement . . . Its prompt action, ability to provide objective and subjective assistance, and freedom from undesirable effects recommend it for use as a muscle relaxant and analgesic drug of great benefit in the conservative management of the 'low back syndrome'."

Kestler, O.: Conservative Management of "Low Back Syndrome", J.A.M.A. 172: 2039 (April 30) 1960.

FASTER IMPROVEMENT—79% complete or marked improvement in 7 days (Kestler)

EASY TO USE—Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

SUPPLIED: 350 mg., white tablets, bottles of 50.
For pediatric use, 250 mg., orange capsules, bottles of 50.

Literature and samples on request.

SOMA®

(CARISOPRODOL, WALLACE)

WALLACE LABORATORIES, CRANBURY, NEW JERSEY

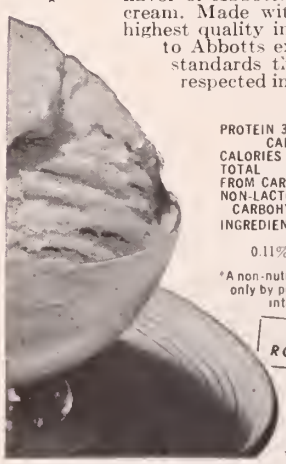
When too many tasks
seem to crowd
the unyielding hours,
a welcome
"pause that refreshes"
with ice-cold Coca-Cola
often puts things
into manageable order.

DRINK
Coca-Cola
REG. U.S. PAT. OFF.

NOW! DIABETICS CAN ENJOY
(UNDER MEDICAL ADVICE)

Abbotts
ARTIFICIALLY SWEETENED
ICE CREAM

Your patients whose sugar intake is restricted will relish the extra delicious flavor of Abbotts new, sugar-free ice cream. Made with infinite care and highest quality ingredients according to Abbotts exacting standards—standards that are most highly respected in the dairy industry.



COMPOSITION

PROTEIN 3.52%	MILK FAT 10.52%	
CARBOHYDRATES 21.35%		
CALORIES PER OUNCE	AVOIR.	FLUID
TOTAL	55.02	33.31
FROM CARBOHYDRATES	24.21	14.66
NON-LACTOSE CARBOHYDRATES	18.03	10.92

INGREDIENTS: CREAM, MILK, SORBITOL, STABILIZER AND 0.11% CYCLAMATE CALCIUM*

*A non-nutritive artificial sweetener for use only by persons who must restrict their intake of ordinary sweets.

IN HANDY ROUND PINTS

At Abbotts
and Jane Logan Dealers
Abbotts Dairies, Inc.

A
logical
prescription for
overweight patients

anorectic-ataractic
BAMADEX®
meprobamate 400 mg., with d-amphetamine sulfate 5 mg., Tablets

meprobamate **plus** d-amphetamine... depresses appetite...elevates mood... eases tensions of dieting...**without** over-stimulation, insomnia or barbiturate hangover.

Dosage: One tablet one-half to one hour before each meal.

Lederle

no irritating crystals[1] · uniform concentration in each drop[2]

STERILE OPHTHALMIC SOLUTION

NEO-HYDELTRASOL®

PREDNISOLONE 21-PHOSPHATE-NEOMYCIN SULFATE

2,000 TIMES MORE SOLUBLE THAN PREDNISOLONE OR HYDROCORTISONE

"The solution of prednisolone has the advantage over the suspension in that no crystalline residue is left in the patient's cul-de-sac or in his lashes . . . . The other advantage is that the patient does not have to shake the drops and is therefore sure of receiving a consistent dosage in each drop."[2]

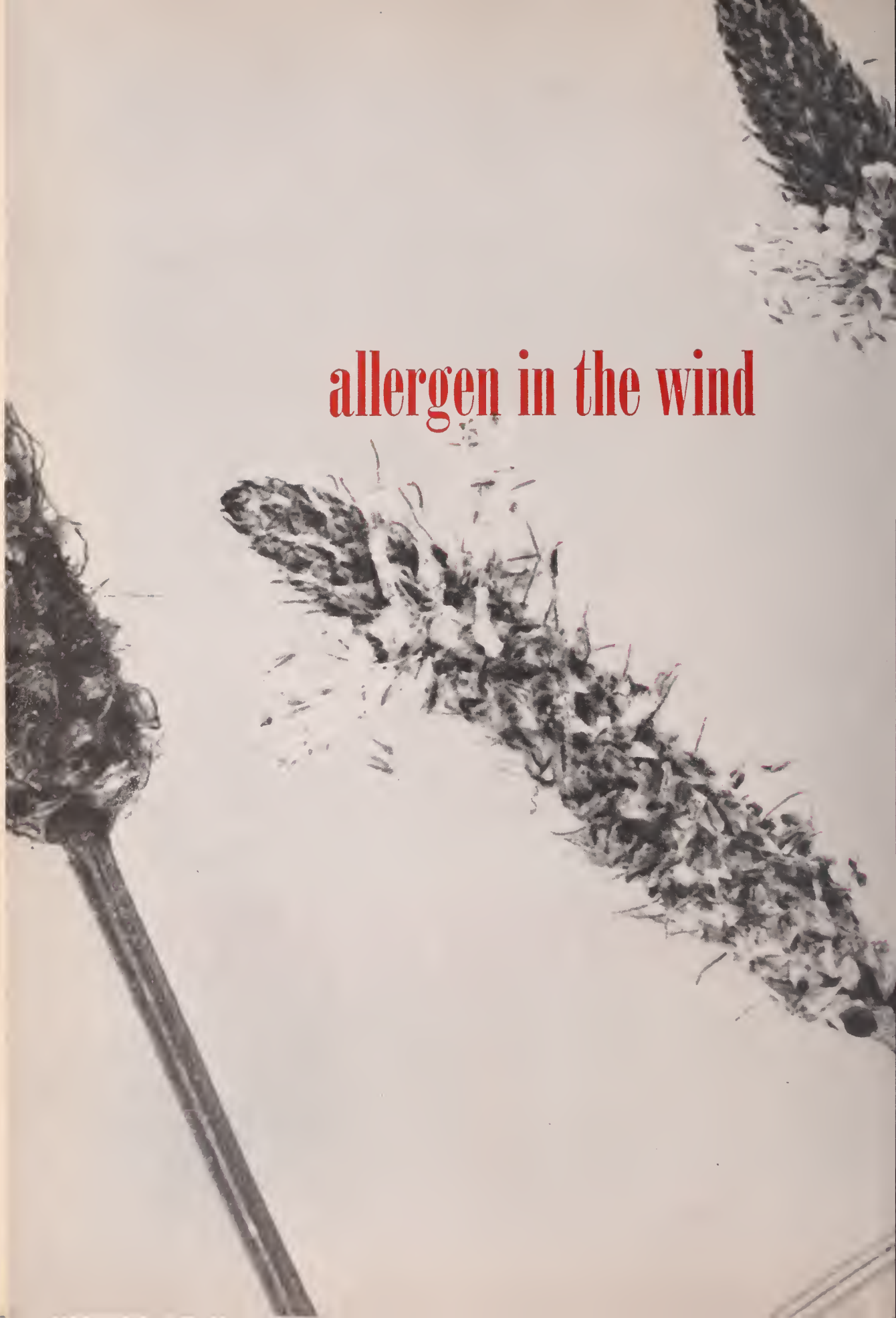
1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957.
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

supplied: 0.5% Sterile Ophthalmic Solution NEO-HYDELTRASOL (with neomycin sulfate) and 0.5% Sterile Ophthalmic Solution HYDELTRASOL®. In 5 cc. and 2.5 cc. dropper vials. Also available as 0.25% Ophthalmic Ointment NEO-HYDELTRASOL (with neomycin sulfate) and 0.25% Ophthalmic Ointment HYDELTRASOL. In 3.5 Gm. tubes.

HYDELTRASOL and NEO-HYDELTRASOL are trademarks of Merck & Co., Inc.

MSD MERCK SHARP & DOHME Division of Merck & Co., Inc., Philadelphia 1, Pa.

allergen in the wind



when pollens harry the unwary

BENADRYL®

antihistaminic-antispasmodic

gives prompt, comprehensive relief

In hay fever, BENADRYL provides simultaneous, dual control of allergic symptoms. Nasal congestion, lacrimation, sneezing, and related histamine reactions are effectively relieved by the *antihistaminic action* of BENADRYL. At the same time, its *antispasmodic effect* alleviates bronchial and gastrointestinal spasms. This duality of action makes BENADRYL valuable throughout a wide range of allergic disorders.

BENADRYL Hydrochloride (diphenhydramine hydrochloride, Parke-Davis) is available in a variety of forms including: Kapseals,® 50 mg. each; Kapseals, 50 mg., with ephedrine sulfate, 25 mg.; Capsules, 25 mg. each; Elixir, 10 mg. per 4 cc.; and for delayed action, Emplets,® 50 mg. each. For parenteral therapy, BENADRYL Hydrochloride Steri-Vials,® 10 mg. per cc.; and Ampoules, 50 mg. per cc. 26760

PARKE-DAVIS

PARKE, DAVIS & COMPANY • DETROIT 32, MICHIGAN

in overweight

℞ **DEXAMYL®**

brand of dextro amphetamine and amobarbital

SPANSULE®

brand of sustained release capsules

for the patient who is tense, irritable, frustrated by inability to stick to diet

SMITH
KLINE &
FRENCH

...and for the patient who is listless, lethargic, depressed by reducing regimens:

℞ DEXEDRINE® SPANSULE®

brand of dextro amphetamine sulfate — brand of sustained release capsules

Each 'Dexamyl' Spansule sustained release capsule (No. 2) contains 'Dexedrine' (brand of dextro amphetamine sulfate), 15 mg., and amobarbital, 1½ gr. Each 'Dexamyl' Spansule capsule (No. 1) contains 'Dexedrine', 10 mg., and amobarbital, 1 gr.
Each 'Dexedrine' Spansule sustained release capsule contains dextro amphetamine sulfate, 5 mg., 10 mg., or 15 mg.

THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

Entered as second-class matter September 5, 1906, at the post office at Orange, New Jersey, under Act of March 3, 1879

Second Class Postage Paid at Orange, N. J.

Vol. 57, No. 9 | SEPTEMBER, 1960 | Subscriptions, $3.00 per Year Single Copies, 30 Cents

THE N Y ACADEMY OF MEDICINE LIBRARY. SEP 26 1960

CONTENTS—Pages 511 to 558

EDITORIALS— Page

Responsible Means Answerable 511

Fraternal Orders and Medical Care 512

ORIGINAL ARTICLES—

Advances in Office Diagnosis in Gynecology—Joseph G. Stella, M.D., Atlantic City, N. J. 513

Cluster Testing—William J. Dougherty, M.D., M.P.H. and David P. Hammond, Trenton, N. J. 517

Infectious Versus Allergic Rhinitis and Sinusitis—Walter A. Petryshyn, M.D., Flemington, N. J. 521

Postoperative Use of Trifluopromazine by the Drip Method—Ben Sheiner, M.D., Westwood, N. J. 525

Renal Hamartoma (Angiomyolipoma)—Robert R. White, III, M.D. and John K. deVries, M.D., Summit, N. J. 528

Obstetrical "Double Setup" in the Operating Room—Bertold Salzmann, M.D., Linden, N. J. 531

Correction of Mitral Insufficiency by Open Heart Surgery—Dryden P. Morse, M.D., Michael Ramundo, M.D. and Theodore R. Keith, M.D., Passaic, N. J. 533

ORIGINAL ARTICLES— Page

A Community Clinic for the Retarded—Nellie D. Stone, M.S.W., East Orange, N. J. 540

Bilateral Carotid Body Tumor—G. Robert Hardy, M.D., New Brunswick, N. J. 544

Acute Leukemia in Monmouth County—Helen E. Jones, M.D., Robert Barnett, M.D. and Anthony DeSpirito, M.D., Asbury Park, N. J. 547

STATE ACTIVITIES—

N. J. Diplomates in Obstetrics and Gynecology 520

Payments Under Medicare 549

Centenary for Dr. Ewen 549

Aviation Medical Examiners 550

New New Jersey ACCP Fellows 550

OBITUARIES 551

ANNOUNCEMENTS 552

COUNTY SOCIETY REPORTS 554

BOOK REVIEWS 554

NTA ABSTRACTS 557

Roster of Officers and Committee Chairmen, Advertising Page 3A

Place of Publication, Printing and Mailing, 116-118 Lincoln Ave., Orange, N. J.

Editorial and Executive Offices of the Society 315 West State St., Trenton 8, N. J.

Address all communications FOR PUBLICATION to editorial office at P.O. Box 904, Trenton 5, N. J.

Telephone EXport 4-3154

Published Monthly Since 1904

Acceptance for mailing at special rate of postage provided for in Sec. 1103, Act of Oct. 3, 1917, authorized July 29, 1918.

Copyright 1960 by The Medical Society of New Jersey

NEW PROFESSIONAL LIABILITY INSURANCE PROGRAM APPROVED BY YOUR MEDICAL SOCIETY

American Mutual has been appointed by the 1960 House of Delegates of The Medical Society of New Jersey to provide your professional liability insurance. (See article in August JOURNAL, page 497.)

This means protection by the *first* American liability insurance company. Long experience in the field of professional liability insurance has led to a practical solution of one of the important problems—that of *loss control*—faced by the medical profession.

Insurance for Professional Liability and Professional Premises Liability is available to members of The Medical Society of New Jersey. Professional Liability Insurance is also available to the registered nurses and qualified technicians employed by our policyholder doctors.

Protection for Libel, Slander and Defamation of Character arising out of activities on committees of State and County Medical Societies and committees of licensed hospitals is furnished to all insured doctors.

Please address your request for further information about this program to:

American Mutual Liability Insurance Company

PROFESSIONAL LIABILITY DEPARTMENT

68 SOUTH HARRISON STREET EAST ORANGE, NEW JERSEY

JOSEPH A. BRITTON, Manager ORANGE 3-2575

HOME OFFICE: WAKEFIELD, MASS.

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766

PLACE OF PUBLICATION, PRINTING AND MAILING, 116 LINCOLN AVE., ORANGE, N. J.

EXECUTIVE AND EDITORIAL OFFICES, 315 WEST STATE STREET, TRENTON 8, N. J. Tel. EXport 4-3154

(MAILING ADDRESS: P.O. BOX 904, TRENTON 5, N. J.)

Mr. Richard I. Nevin, *Executive Officer* ..... Trenton
Mrs. Edith L. Madden, *Administrative Secretary and Convention Manager* ..... Trenton
Henry A. Davidson, *Editor* ..... Cedar Grove
Mrs. Miriam N. Armstrong, *Assistant Editor* ..... Trenton

OFFICERS

President, Jesse McCall ..... Newton
President-Elect, Ralph M. L. Buchanan ..... Phillipsburg
First Vice-President, Louis S. Wegryn ..... Elizabeth
Second Vice-President, Carl N. Ware ..... Shiloh
Secretary, Marcus H. Greifinger ..... Newark
Treasurer, Daniel F. Featherston ..... Asbury Park

TRUSTEES

Luke A. Mulligan, *Chairman* (1962) ..... Leonia
Jerome G. Kautman, *Secretary* (1961) ..... Newark
Jesse McCall ..... Newton
Ralph M. L. Buchanan ..... Phillipsburg
Louis S. Wegryn ..... Elizabeth
Carl N. Ware ..... Shiloh
Marcus H. Greifinger ..... Newark
Daniel F. Featherston ..... Asbury Park
F. Clyde Bowers ..... Mendham
David B. Allman (1962) ..... Atlantic City
John J. Bedrick (1963) ..... Bayonne
Nicholas A. Bertha (1962) ..... Wharton
C. Byron Blaisdell (1961) ..... Asbury Park
Louis K. Collins (1961) ..... Glassboro
Lloyd A. Hamilton (1962) ..... Lambertville
Frank J. Hughes (1963) ..... Gloucester
Joseph R. Jehl (1963) ..... Clifton
Samuel J. Lloyd (1963) ..... Trenton

COUNCILORS

First District (Union, Warren, Morris and Essex Counties) ..... Emanuel M. Satulsky, Elizabeth (1963)
Second District (Sussex, Bergen, Hudson and Passaic Counties) ..... John L. Olpp, Englewood (1962)
Third District (Mercer, Middlesex, Somerset and Hunterdon Counties) ..... Charles H. Calvin, Perth Amboy (1961)
Fourth District (Camden, Burlington, Ocean and Monmouth Counties) ..... E. Vernon Davis, Moorestown (1963)
Fifth District (Cape May, Cumberland, Atlantic, Gloucester and Salem Counties) ..... Isaac N. Patterson, Westville (1962)

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Delegates

C. Byron Blaisdell (1960) ..... Asbury Park
William F. Costello (1961) ..... Dover
Aldrich C. Crowe (1961 ..... Ocean City
J. Wallace Hurff (1960) ..... Newark
L. Samuel Sica (1960) ..... Trenton
Elmer P. Weigel (1960) ..... Plainfield

Alternates

Ralph M L. Buchanan (1960) ..... Phillipsburg
Joseph P. Donnelly (1961) ..... Jersey City
Elton W. Lance (1961) ..... Rahway
Jesse McCall (1960) ..... Newton
Herschel Pettit (1960) ..... Ocean City
John H. Rowland (1960) ..... New Brunswick

DELEGATES TO OTHER STATES

New York—William F. Costello (1961) ..... Dover
Connecticut—Lloyd A. Hamilton (1961) ..... Lambertville
New York—Levi M. Walker (1961) ..... Atlantic City
Connecticut—S. Eugene Dalton (1961) ..... Ventnor

COMMITTEE CHAIRMEN — 1960-61

Annual Meeting ..... Jerome G. Kaufman, Newark
..... Vice-Chairman—Edward E. P. Seidmon, Plainfield
Cancer Control ..... John L. Olpp, Englewood
Child Health ..... Robert E. Jennings, South Orange
Chronically Ill and Aging ..... William H. Hahn, Newark
Constitution and Bylaws ..... Louis F. Albright, Spring Lake
..... Vice-Chairman—Joseph M. Gannon, Plainfield
Credentials ..... M. H. Greifinger, Newark
..... Vice-Chairman—Eugene J. Tyrrell, Perth Amboy
Disaster Medical Services ..... R. Winfield Betts, Medford
Finance and Budget ..... David B. Allman, Atlantic City
..... Vice-Chairman—Carl N. Ware, Shiloh
Hearing and Speech ..... S. Eugene Dalton, Ventnor
Honorary Membership ..... Aldrich C. Crowe, Ocean City
..... Vice-Chairman Royal A. Schaaf, Califon
Industrial Health ..... Willis B. Mitchell, Toms River
Legislation ..... C. Byron Blaisdell, Asbury Park
..... Vice-Chairman—A. Guy Campo, Westville
Maternal and Infant Welfare ..... John D. Preece, Trenton
Medical Defense and Insurance ..... Daniel F. Featherston, Asbury Park
..... Vice-Chairman—Benjamin F. Slobodien, Perth Amboy
Medical Education ..... Sherman Garrison, Jr., Bridgeton
..... Vice-Chairman—Morris H. Saffron, Passaic
Medical Services ..... Irving Klompus, Bound Brook
..... Vice-Chairman—Nicholas E. Marchione, Vineland
Medical Student Loan Fund ..... Luke A. Mulligan, Leonia
..... Vice-Chairman—Vincent P. Butler, Jersey City
Mental Health ..... John J. Mackin, Jersey City
Physicians Placement Service ..... Samuel J. Lloyd, Trenton
Publication ..... Fred B. Rogers, Trenton
..... Vice-Chairman—C. Spencer Davison, Salem
Public Health ..... Robert S. Garber, Belle Mead
..... Vice-Chairman—John B. Fuhrmann, Flemington
Public Relations ..... John F. Kustrup, Trenton
..... Vice-Chairman—John J. Torppey, Newark
Rehabilitation ..... Elmer J. Elias, Trenton
Scientific Exhibit ..... Milton Ackerman, Atlantic City
Scientific Program ..... Edward E. P. Seidmon, Plainfield
Traffic Safety ..... A. M. K. Maldeis, Camden
Vision ..... Samuel M. Diskan, Atlantic City
Woman's Auxiliary ..... Lewis C. Fritts, Somerville
..... Vice-Chairman—A. Guy Campo, Westville
Workmen's Compensation ..... Joseph A. Lepree, Elizabeth

Blood pressure that goes up with stress often comes down with SERPASIL®

(reserpine CIBA)

One reason that many cases of hypertension respond to Serpasil is that many cases are associated with stress. Stress situations produce stimuli which pass through the sympathetic nerves, constricting blood vessels, and increasing heart rate. Hyperactivity of the sympathetic nervous system may elevate blood pressure; if prolonged, this may produce frank hypertension. By blocking the flow of excessive stimuli to the sympathetic nervous system, Serpasil guards against stress-induced vasoconstriction, brings blood pressure down slowly and gently.

In mild to moderate hypertension, Serpasil is basic therapy, effective alone "...in about 70 per cent of cases..."*

In severe hypertension, Serpasil is valuable as a primer. By adjusting the patient to the physiologic setting of lower pressure, it smooths the way for more potent antihypertensives.

In all grades of hypertension, Serpasil may be used as a background agent. By permitting lower dosage of more potent antihypertensives, Serpasil minimizes the incidence and severity of their side effects.

CIBA
SUMMIT, N. J.

*Coan, J. P., McAlpine, J. C., and Boone, J. A.: J. South Carolina M. A. 51:417 (Dec.) 1955. /2830MB

Complete information available on request.

State Medical Society Plans of Accident and Health Insurance Providing Coverage Up to $1,000 Monthly

THE MEDICAL SOCIETY OF NEW JERSEY officially selected the NATIONAL CASUALTY COMPANY in 1933 to underwrite its exclusively recognized group plan of accident and health insurance and officially selected the NATIONWIDE MUTUAL INSURANCE COMPANY in 1958 to underwrite its **additional** plan of accident and health insurance. Applications are invited from Society members who have not as yet applied; policies are available to applicants in accordance with Company rules and regulations for acceptance of risks.

BRIEF OUTLINE OF COVERAGE
NATIONAL CASUALTY COMPANY PLAN

(THE COMPLETE TERMS OF THE INSURANCE COVERAGE ARE SET FORTH IN THE POLICY)

ACCIDENTAL BODILY INJURY BENEFITS —Full monthly benefit for total disability, from FIRST DAY, limit 60 months. One-half monthly benefit for partial disability, limit 6 months. Limit of time for total and partial combined 60 months. (Total disability coverage extendable to lifetime.†)

SICKNESS BENEFITS —Full monthly benefit for total disability commencing with EIGHTH DAY of disability, limit 24 months, house confinement not required. (Total disability coverage extendable to 7 years.†)

(Regular care and attendance by a legally qualified physician or surgeon, other than yourself, required during period of disability.)

CONDITIONS OF RENEWABILITY —Once issued, the policy cannot be ridered for recurrent disability nor can it be terminated so long as the Society plan is in existence, except for non-payment of premium, if the insured retires or ceases to be actively engaged in the medical profession, if he ceases to be an active member of The Medical Society of New Jersey, or if renewal is refused on all policies issued to all members of the society, In which event 60 days prior notice in writing must be given.

EXCEPTIONS —Injury due to the hazards of warfare; suicide or intentionally self-inflicted injury, or any attempt thereat, while sane or insane; air travel, except passenger air travel as provided in the policy; all are not covered.

ANNUAL PREMIUM RATES*

(Applicable to ages at entry and attained at annual renewal of insurance)

Monthly Benefits	Dismemberment Benefits	Ages up to 50 Next Birthday	Ages 51 to 60 Next Birthday	Ages 61 to 65 ** Next Birthday
$100.00	$ 5,000	$ 29.50	$ 34.00	$ 43.00
150.00	7,500	43.60	50.35	63.85
200.00	10,000	57.70	66.70	84.70
300.00	15,000	85.90	99.40	126.40
400.00	20,000	114.10	132.10	168.10
500.00	20,000	141.30	163.80	208.80
‡ 600.00	20,000	168.50	195.50	249.50

* Premiums may be paid half-yearly or quarterly, pro-rata.

* All rates above INCLUDE $1000 Accidental Death Benefit.

** Although the age limit for acceptance of risks is the 65th birthday, once issued there is no termination age limit for renewal.

† Extension of sickness benefits to seven years and accident benefits for life available to holders of the above policy under age 60, in accordance with the company's underwriting regulations, through the EXTENDED PROFESSIONAL DISABILITY POLICY which is renewable to the 65th birthday. Ask about its coverage and modest additional cost.

‡ **ADDITIONAL BASIC COVERAGE UP TO $400 MONTHLY AVAILABLE THROUGH THE OFFICIALLY APPROVED NATIONWIDE MUTUAL INSURANCE COMPANY WITH SIMILAR RATES AND COVERAGE AND WHICH IS RENEWABLE TO AGE 70. Full details on all plans sent on request.**

NATIONAL CASUALTY COMPANY
through
E. and W. BLANKSTEEN

NATIONWIDE MUTUAL INSURANCE CO.
through
E. and W. BLANKSTEEN AGENCY, Inc.

75 MONTGOMERY STREET **DELAWARE 3-4340** **JERSEY CITY 2, N. J.**

alert tranquillity

a new, improved, more potent relaxant for anxiety and tension

- effective in half the dosage required with meprobamate
- much less drowsiness than with meprobamate, phenothiazines, or the psychosedatives
- does not impair intellect, skilled performance, or normal behavior
- neither depression nor significant toxicity has been reported

alert tranquillity

Striatran®

EMYLCAMATE

- a familiar spectrum of antianxiety and muscle-relaxant activity
- no new or unusual effects—such as ataxia or excessive weight gain
- may be used in full therapeutic dosage even in geriatric or debilitated patients
- no cumulative effect
- simple, uncomplicated dosage, providing a wide margin of safety for office use

STRIATRAN is indicated in anxiety and tension, occurring alone or in association with a variety of clinical conditions.

Adult Dosage: One tablet three times daily, preferably just before meals. In insomnia due to emotional tension, an additional tablet at bedtime usually affords sufficient relaxation to permit natural sleep.

Supply: 200 mg. tablets, coated pink, bottles of 100.

While no absolute contraindications have been found for Striatran in full recommended dosage, the usual precautions and observations for new drugs are advised.

For additional information, write Professional Services, Merck Sharp & Dohme, West Point, Pa.

MSD MERCK SHARP & DOHME, DIVISION OF MERCK & CO., INC., WEST POINT, PA.

STRIATRAN IS A TRADEMARK OF MERCK & CO., INC.

in arthritis and allied disorders

Butazolidin®
brand of phenylbutazone
Geigy

Proved by a Decade of Experience
Confirmed by 1700 Published Reports
Attested by World-Wide Usage

Since its anti-inflammatory properties were first noted in Geigy laboratories 10 years ago, time and experience have steadily fortified the position of Butazolidin as a leading nonhormonal anti-arthritic agent. Indicated in both chronic and acute forms of arthritis, Butazolidin is noted for its striking effectiveness in relieving pain, increasing mobility and halting inflammatory change.

Butazolidin®, brand of phenylbutazone: Red, sugar-coated tablets of 100 mg. Butazolidin® Alka: Orange and white capsules containing Butazolidin 100 mg.; dried aluminum hydroxide gel 100 mg.; magnesium trisilicate 150 mg.; homatropine methylbromide 1.25 mg.

Geigy, Ardsley, New York

162-60

The physician listens to a tense, nervous patient discuss her emotional problems. To help her, he prescribes Meprospan® (400 mg.), the only continuous-release form of meprobamate.

The patient takes one Meprospan-400 capsule at breakfast. She has been suffering from recurring states of anxiety which have no organic etiology.

She stays calm while on Meprospan, even under the pressure of busy, crowded supermarket shopping. And she is not likely to experience any autonomic side reactions, sleepiness or other discomfort.

She takes another capsule of Meprospan-400 with her evening meal. She has enjoyed sustained tranquilization all day—and has had no between-dose letdowns. Now she can enjoy sustained tranquilization all through the night.

Relaxed, alert, attentive . . . she is able to listen carefully to P.T.A. proposals. For Meprospan does not affect either her mental or her physical efficiency.

Peacefully asleep . . . she rests, undisturbed by nervousness or tension. (Samples and literature on Meprospan available from Wallace Laboratories, Cranbury, N. J.)

Doctor: One of a series of ads appearing in local newspapers—telling your story to the public

Published to give you the *Who . . . What . . .*
When . . . Where . . . Why of Blue Shield

WHY?

Ask the average BLUE SHIELD member why he has this protection and you'll probably get a number of good reasons. However, when you sift them down, you'll find this: **He has selected BLUE SHIELD because it represents the best value in medical protection he can get for his dollar.** BLUE SHIELD is striving constantly to give its members not only a full measure of protection but a service that has grown up with the changing times . . . that gives them *what* they need *when* they need it. Today, there are many kinds of medical cost protection plans. Compare BLUE SHIELD with any of them . . . and prove to yourself that you are getting a fuller dollar's worth when you carry BLUE SHIELD. Nearly 2,000,000 enrolled persons in New Jersey will agree!

BLUE SHIELD MEDICAL-SURGICAL PLAN OF NEW JERSEY
NEWARK
TRENTON
CAMDEN

Each of the babies pictured on this page was borne by a mother with a *documented* previous history of true habitual abortion, who was treated with DELALUTIN during the pregnancy leading to this birth

LIVING PROOF OF FETAL SALVAGE WITH

DELALUTIN

SQUIBB HYDROXYPROGESTERONE CAPROATE

Improved Progestational Therapy

Garden City, N. Y.

Lincolnwood, Ill.

Skokie, Ill.

Denver, Colo.

Denver, Colo.

No. Massapequa, L. I., N. Y.

Roselle, Ill.

Seaford, N. Y.

Hartford, Conn.

East Williston, N. Y.

Norwich, Vt.

DELALUTIN offers these advantages over other progestational agents

• long-acting sustained therapy • more effective in producing and maintaining a completely matured secretory endometrium • no androgenic effect • more concentrated solution requiring injection of less vehicle • unusually well-tolerated, even in large doses • fewer injections required • low viscosity makes administration easy

Complete information on administration and dosage is supplied in the package insert

Supply:
Vials of 2 and 10 cc., each containing 125 mg. of hydroxyprogesterone caproate in benzyl benzoate and sesame oil.

Also available: DELALUTIN 2X in 5 cc. multiple-dose vials. Each cc. contains 250 mg. hydroxyprogesterone caproate in castor oil, preserved with benzyl alcohol.

SQUIBB *Squibb Quality—The Priceless Ingredient*

'DELALUTIN'® IS A SQUIBB TRADEMARK

Bed of Digitalis purpurea
with Campanula (Canterbury Bells) in foreground

Not far from here are manufactured
from the powdered leaf
Pil. Digitalis (Davies, Rose)
0.1 Gram (1½ grains) or 1 U.S.P. Digitalis Unit.
They are physiologically standardized,
with an expiration date on each package.
Being Digitalis in its completeness,
this preparation comprises the
entire therapeutic value of the drug.
It provides the physician with a safe and effective
means of digitalizing the cardiac patient
and of maintaining the necessary saturation.
Security lies in prescribing the
"original bottle of 35 pills, Davies, Rose."

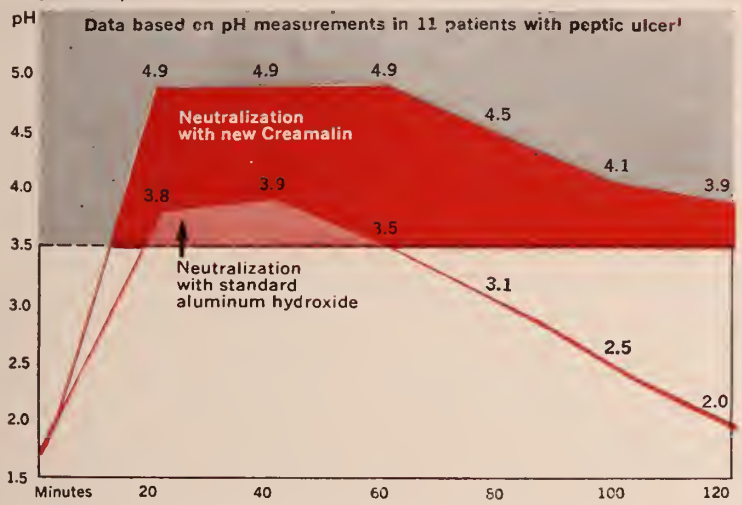
Clinical samples and literature sent to physicians on request

Davies, Rose & Co., Ltd. Boston 18, Mass.

D 27

At the site of peptic ulcer

Following determination of basal secretion, intragastric pH was continuously determined by means of frequent readings over a two-hour period.



neutralization is much faster and twice as long with

New CREAMALIN® ANTACID TABLETS

New proof in vivo[1] of the much greater efficacy of new Creamalin tablets over standard aluminum hydroxide has now been obtained. Results of comparative tests on patients with peptic ulcer, measured by an intragastric pH electrode, show that new Creamalin neutralizes acid from 40 to 65 per cent faster than the standard preparation. This neutralization (pH 3.5 or above) is maintained for approximately one hour longer.

New Creamalin provides virtually the same effects as a liquid antacid[2] with the convenience of a tablet.

Nonconstipating and pleasant-tasting, new Creamalin antacid tablets will not produce "acid rebound" or alkalosis.

Each new Creamalin antacid tablet contains 320 mg. of specially processed, highly reactive, short polymer dried aluminum hydroxide gel (stabilized with hexitol) with 75 mg. of magnesium hydroxide. Minute particles of the powder offer a vastly increased surface area for quicker and more complete acid neutralization.

Dosage: Gastric hyperacidity — from 2 to 4 tablets as necessary. Peptic ulcer or gastritis — from 2 to 4 tablets every two to four hours. Tablets may be chewed, swallowed whole with water or milk, or allowed to dissolve in the mouth. **How supplied:** Bottles of 50, 100, 200 and 1000.

1. Data in the files of the Department of Medical Research, Winthrop Laboratories. 2. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: **J. Am. Pharm. A.** (Scient. Ed.) 48:384, July, 1959.

Winthrop LABORATORIES
New York 18, N. Y.

for peptic ulcer ■ gastritis ■ gastric hyperacidity

wherever there is inflammation, swelling, pain

VARIDASE®

Streptokinase-Streptodornase Lederle

BUCCAL Tablets

conditions for a fast & comfortable comeback

Host reaction to injury or local infection has a catabolic and an anabolic phase. The body responds with inflammation, swelling and pain. In time, the process is reversed. VARIDASE speeds up this normal process of recovery.

By activating fibrinolytic factors VARIDASE shortens the *undesirable phase*, limits necrotic changes due to inflammatory infiltration, and initiates the constructive phase to speed total remission. Medication and body defenses can readily penetrate to the affected site; local tissue is prepared for faster regrowth of cells. In infection, the fibrin wall is breached while the infection-limiting effect is retained. In acute cases, response is often dramatic. In chronic cases, VARIDASE Buccal Tablets can stimulate a successful response to primary therapy previously considered inadequate or failing.

for routine use in injury and infection
...new simple buccal route

VARIDASE Buccal Tablets should be retained in the buccal pouch until dissolved. For maximum absorption, patient should delay swallowing saliva.

Dosage: One tablet four times daily usually for five days. When infection is present, VARIDASE Buccal Tablets should be given in conjunction with ACHROMYCIN® V Tetracycline with Citric Acid.

Each VARIDASE Buccal Tablet contains: 10,000 Units Streptokinase and 2,500 Units Streptodornase.

Supplied: boxes of 24 and 100 tablets.

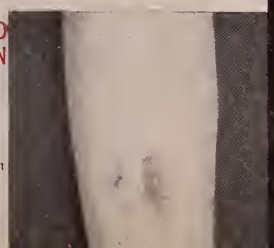
1. Innerfield, I.: Clinical report cited with permission
2. Clinical report cited with permission

Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY
Pearl River, New York

ORCE INJURY
evere bruises
. . . swelling
. . . cleared
by fifth day[2]

VARICOSE
ULCER
15 years duration
. . . resolved with
VARIDASE[1]

INFLAMMATORY
DERMATOSIS
rapidly spreading
rhus dermatitis
healed within
a week[1]



INFECTED
LACERATION
rked reversal
in 3 days . . .
returned
to school . . .
ure advanced[1]

THROMBOPHLEBITIS
back on his feet
in a week after
recurrent episode[1]

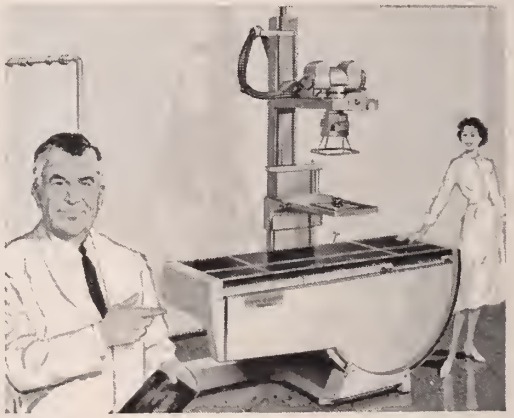
REFRACTORY
CELLULITIS
normal routine
resumed after 4 days
of VARIDASE[1]

Don't settle for "slow-power" x-ray

get a full 200-ma with your Patrician combination

When anatomical motion threatens to blur radiographs, the 200-ma Patrician can answer with extreme exposure speed, *twice* that of any 100-ma installation. Film images show improved diagnostic readability . . . retakes are fewer. And you'll find the G-E Patrician is like this in everything for radiography and fluoroscopy: built right, priced sensibly, *uncompromising* in assuring you all basic professional advantages. Full-size 81″ table . . . independent tubestand . . . shutter limiting device . . . automatic tube protection . . . counterbalanced fluoroscope, x-ray tube and Bucky . . . full-wave x-ray output.

You also can rent the Patrician— through G-E Maxiservice® x-ray rental plan. Gives you the complete x-ray unit, *plus* maintenance, parts, tubes, insurance, local taxes — *everything*—for one, uniform monthly fee. Get details from your local G-E x-ray representative listed below.



Progress Is Our Most Important Product

GENERAL ELECTRIC

DIRECT FACTORY BRANCHES

NEWARK
Springfield—52 Commerce St. • DRexel 9-4865

PHILADELPHIA
Hunting Pk. Ave. at Ridge • BAldwin 5-7600

when pressure is a problem

Reduce pressure through bradycardic, tranquillizing action....

'Rauwistan'

the MRT-standardized Rauwolfia

BECAUSE its unique chemical and biological standardization assures **uniformity and consistency of effect** time after time with high activity and minimal incidence of side effects.

SUPPLIED: Tablets of 50 and 100 mg., in bottles of 100.

DOSAGE: 100 to 300 mg. daily, in divided doses.

Reduce pressure through bradycardic, tranquillizing plus direct hypotensive action....

'Verwolfia'

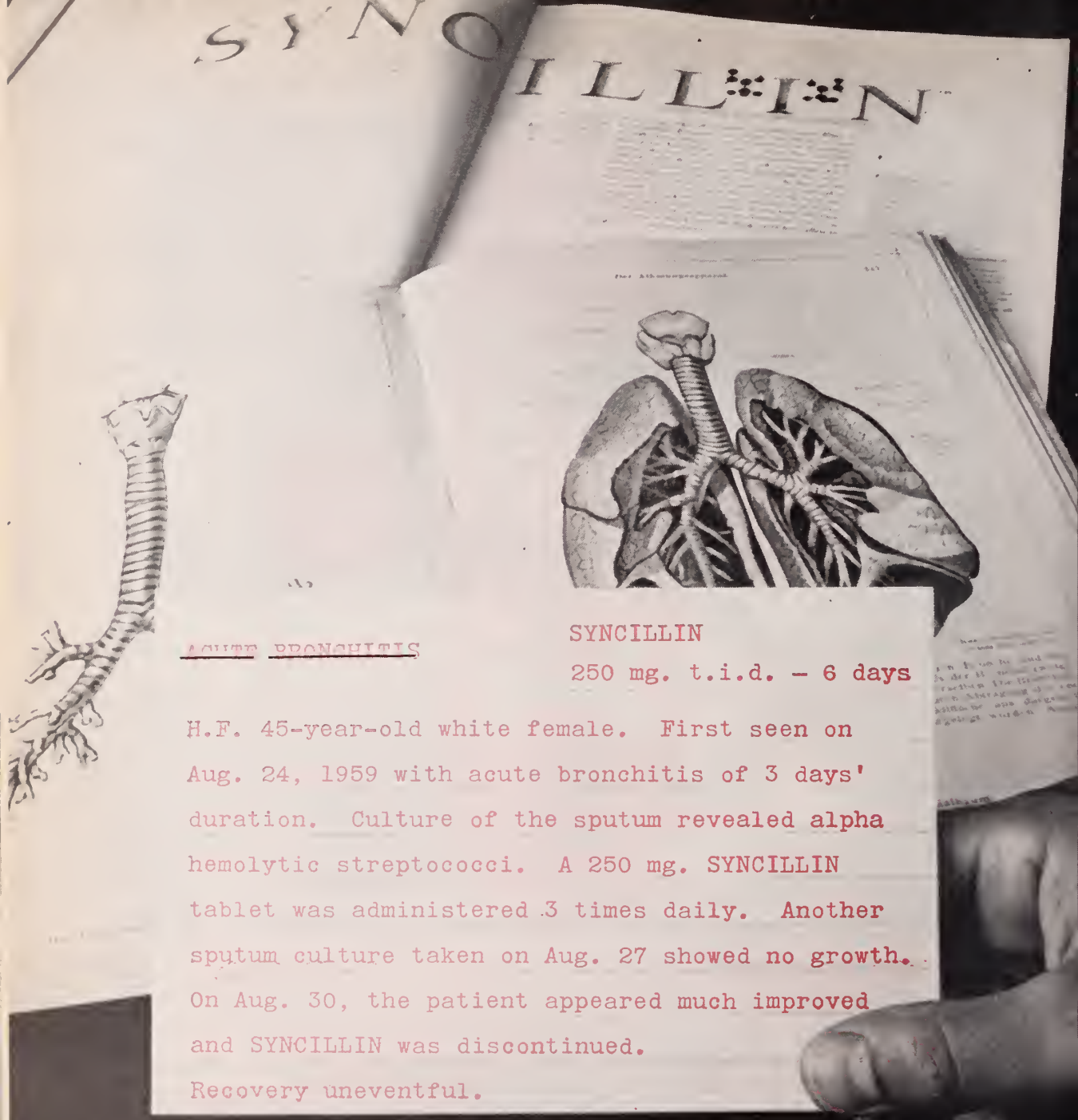
the MRT-standardized Rauwolfia-Veratrum

BECAUSE it adds to Rauwistan the specific hypotensive effect of uniquely standardized Veratrum and assures **uniformity and consistency of effect** time after time with high activity and minimal incidence of side effects.

SUPPLIED: 50 mg. of Rauwolfia serpentina and of Veratrum viride (standardized whole root) in each tablet; in bottles of 50 and 100.

DOSAGE: 1 to 3 tablets daily for the first 2 or 3 days; then 1 or 2 tablets daily, as required.

MRT *M. R. Thompson, Inc.* Cranford, N. J.



Actual case summary from the files of Bristol Laboratories' Medical Department

THE ORIGINAL potassium phenethicillin

SYNCILLIN®

(Potassium Penicillin-152)

A dosage form to meet the individual requirements of patients of all ages in home, office, clinic, and hospital:

Syncillin Tablets – 250 mg. (400,000 units)... Syncillin Tablets – 125 mg. (200,000 units)
Syncillin for Oral Solution – 60 ml. bottles – when reconstituted, 125 mg. (200,000 units) per 5 ml.
Syncillin Pediatric Drops – 1.5 Gm. bottles. Calibrated dropper delivers 125 mg. (200,000 units)

Complete information on indications, dosage and precautions is included in the circular accompanying each package.

BRISTOL LABORATORIES, SYRACUSE, NEW YORK BRISTOL™

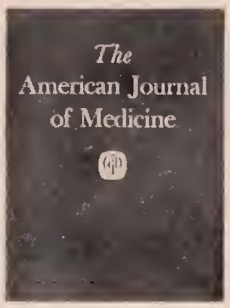
A. H. Robins' new Adabee — for the physician who has weighed the . . .

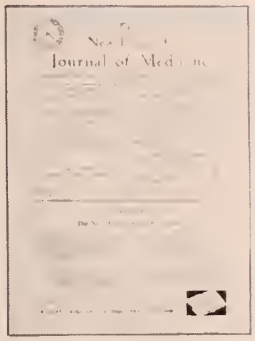
MOUNTING EVIDENCE

AGAINST

B_{12} AND FOLIC ACID

IN MULTI-VITAMINS





Individually, folic acid and B_{12} fill important clinical roles.[1] But, increasing evidence indicates that multivitamins containing folic acid may obscure the diagnosis of pernicious anemia.[2-7] And vitamin B_{12}, in indiscriminate and unnecessary usage[5-8] is likewise blamed for this diagnostic confusion.[7]

Both folic acid and B_{12} have been omitted from Adabee, in recognition of this growing medical concern. Also excluded are other factors which might interfere with concurrent therapy, such as, hormones, enzymes, amino acids, and yeast derivatives. Adabee supplies massive doses of therapeutically practical vitamins for use in both specific and supportive schedules in illness and stress situations. Thus, new Adabee offers the therapeutic advantage of sustained maximum multivitamin support without the threat of symptom-masking.

references: 1. Wintrobe, M. M., *Clinical Hematology*, 3rd ed., Phila., Lea & Febiger, 1952, p. 398. 2. Goodman, L. S. and Gilman, A., *The Pharmacological Basis of Therapeutics*, 2nd. ed., New York, Macmillan, 1955, p. 1709. 3. New Eng. J.M., Vol. 259, No. 25, Dec. 18, 1958, p. 1231. 4. Frohlich, E. D., New Eng. J.M., 259:1221, 1958. 5. J.A.M.A., 169:41, 1959. 6. J.A.M.A., 173:240, 1960. 7. Goldsmith, G. A., American J. of M., 25:680, 1958. 8. Darby, W. J., American J. of M., 25:726, 1958.

ADABEE®

Each yellow, capsule-shaped tablet contains:

Vitamin A	25,000 USP units
Vitamin D	1,000 USP units
Thiamine mononitrate (B_1)	15 mg.
Riboflavin (B_2)	10 mg.
Pyridoxine HCl (B_6)	5 mg.
Nicotinamide (niacinamide)	50 mg.
Calcium pantothenate	10 mg.
Ascorbic acid (vitamin C)	250 mg.

ADABEE® M

Each green, capsule-shaped tablet contains Adabee plus nine essential minerals:

Iron	15.0 mg.	Zinc	1.5 mg.
Iodine	0.15 mg.	Potassium	5.0 mg.
Copper	1.0 mg.	Calcium	103.0 mg.
Manganese	1.0 mg.	Phosphorus	80.0 mg.
Magnesium	6.0 mg.		

indications: As dietary supplements for the deficiency states that accompany pregnancy and lactation, surgery, burns, trauma, alcohol ingestion, hyperthyroidism, infections, cardiac disease, polyuria, anorexia, cirrhosis, arthritis, colitis, diabetes mellitus, and degenerative diseases. Also in restricted diets, particularly peptic ulcer, in geriatrics, and in concurrent administration with diuretics and antibiotics.

dosage: One or more tablets a day, as indicated, preferably with meals.

new! ADABEE

the multivitamin without B_{12} or folic acid

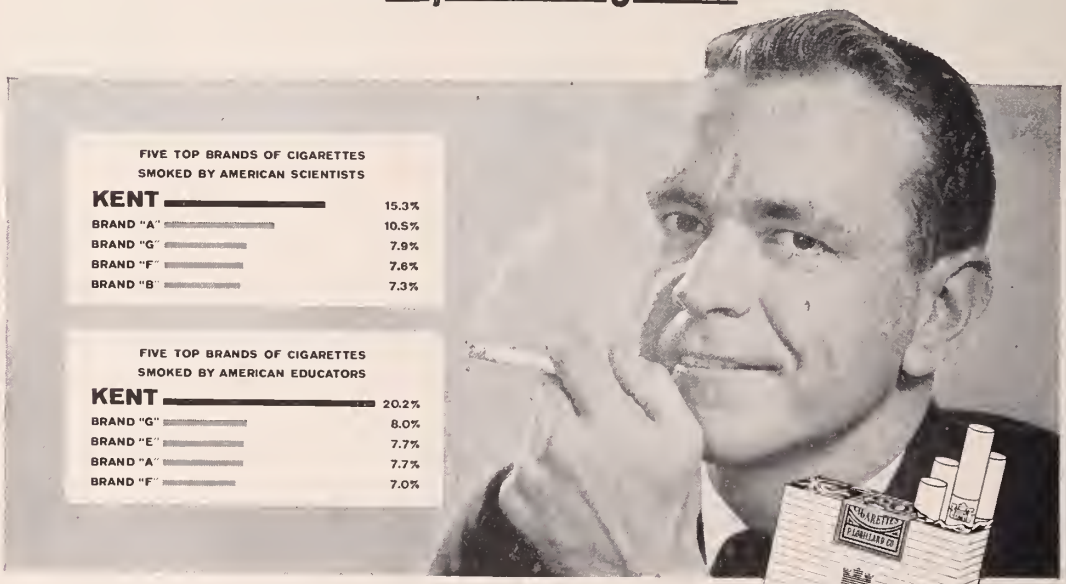
A. H. ROBINS COMPANY, INC.

Richmond 20, Virginia

ALL OVER AMERICA!

KENT with the MICRONITE FILTER IS SMOKED BY MORE SCIENTISTS and EDUCATORS

than any other cigarette!*



THIS does not constitute a professional endorsement of Kent. But these men, like millions of other Kent smokers, smoke for pleasure, and choose their cigarette accordingly.

The rich pleasure of smoking Kent comes from the flavor of the world's finest natural tobaccos, and the free and easy draw of Kent's famous Micronite Filter.

KING-SIZE, REGULAR-SIZE OR CRUSH-PROOF BOX

If you would like the booklet, "The Story of Kent", for your own use, write to: P. Lorillard Company—Research Department, 200 East 42nd Street, New York 17, New York.

For good smoking taste, it makes good sense to smoke KENT

* Results of a continuing study of cigarette preferences, conducted by O'Brien Sherwood Associates, N.Y., N.Y.

A PRODUCT OF P. LORILLARD COMPANY FIRST WITH THE FINEST CIGARETTES THROUGH LORILLARD RESEARCH

© 1960, P. LORILLARD CO.

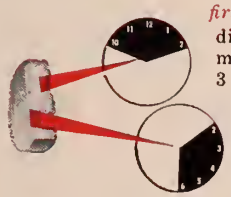
"I wouldn't be hooting all night if I were able to get my beak on some TRIAMINIC® to clear up my stuffed sinuses."

...and for humans with STUFFED-UP SINUSES...

Your patient with sinus congestion doesn't give a hoot about anything but prompt relief. And TRIAMINIC has a pharmacologically balanced formula designed to give him just that. As soon as he swallows the tablet, the medication is transported *systemically* to *all* nasal and paranasal membranes – reaching inaccessible sinus cavities where drops and sprays can never penetrate. TRIAMINIC thereby brings more complete, more effective relief without hazards of topical therapy, such as ciliary inhibition, rebound congestion, and "nose drop addiction."

Indications: nasal and paranasal congestion, sinusitis, postnasal drip, upper respiratory allergy.

Relief is prompt and prolonged because of this special timed-release action:



first – the outer layer dissolves within minutes to produce 3 to 4 hours of relief

then – the core disintegrates to give 3 to 4 *more* hours of relief

Each Triaminic timed-release Tablet provides:

Phenylpropanolamine HCl	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

Dosage: 1 tablet in the morning, midafternoon and at bedtime. In postnasal drip, 1 tablet at bedtime is usually sufficient.

Each timed-release Triaminic Juvelet® provides:
½ the formulation of the Triaminic Tablet.
Dosage: 1 Juvelet in the morning, midafternoon and at bedtime.

Each tsp. (5 ml.) of Triaminic Syrup provides:
¼ the formulation of the Triaminic Tablet.
Dosage (to be administered every 3 or 4 hours):
Adults – 1 or 2 tsp.; *Children 6 to 12* – 1 tsp.;
Children 1 to 6 – ½ tsp.; *Children under 1* – ¼ tsp.

TRIAMINIC®

timed-release tablets, juvelets, and syrup

STOP *running noses* *and open stuffed noses orally*

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska

"...extraordinarily effective diuretic..."[1]

Efficacy and expanding clinical use are making Naturetin the "diuretic of choice"[2] in edema and hypertension. It maintains a favorable urinary sodium-potassium excretion ratio, retains a balanced electrolyte pattern, and causes a relatively small increase in the urinary pH.[3] More potent than other diuretics, Naturetin usually provides 18-hour diuretic action with just a single 5 mg. tablet per day — economical, once-a-day dosage for the patient. Naturetin c̄ K — for added protection in those special conditions predisposing to hypokalemia and for patients on long-term therapy.

Supplied: Naturetin Tablets, 5 mg., scored, and 2.5 mg. Naturetin c̄ K (5 c̄ 500) Tablets, capsule-shaped, containing 5 mg. benzydroflumethiazide and 500 mg. potassium chloride. Naturetin c̄ K (2.5 c̄ 500) Tablets, capsule-shaped, containing 2.5 mg. benzydroflumethiazide and 500 mg. potassium chloride. For complete information consult package circular or write Professional Service Dept., Squibb, 745 Fifth Avenue, New York 22, N. Y.

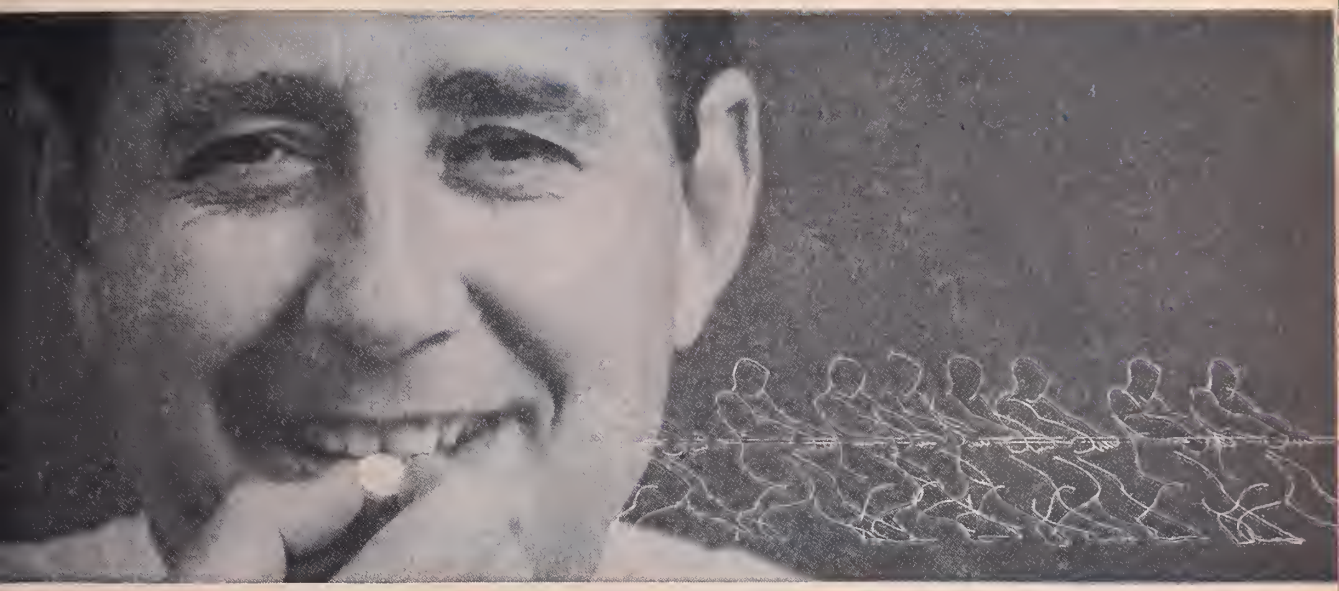
References: 1. David, N. A.; Porter, G. A., and Gray, R. H.: Monographs on Therapy 5:60 (Feb.) 1960. 2. Friend, D. H.; Clin. Pharm. & Therap. 1:5 (Mar.-Apr.) 1960. 3. Ford, R. V.: Current Therap. Res. 2:92 (Mar.) 1960.

Naturetin Squibb Benzydroflumethiazide **Naturetin c̄ K** Squibb Benzydroflumethiazide with Potassium Chloride

SQUIBB

"NATURETIN" & c̄ IS A SQUIBB TRADEMARK.

in antacid therapy...
patient cooperation is half the battle



Are you chancing unsatisfactory results because the patient doesn't like the taste of the antacid you have prescribed? Assure patient cooperation. Prescribe the antacid which assures patient acceptance through its excellent palatability.

'Palatable Margel'

unsurpassed in performance
unequalled in palatability

antacid suspension/tablets

MARGEL is a highly palatable formulation of four antacids: selected aluminum hydroxides, magnesium hydroxide, magnesium trisilicate and calcium carbonate. Balanced to be non-constipating; formulated to be non-chalky. Write for a sample and see for yourself.

Supplied: Margel Suspension — bottles of 12 fluid ounces. Margel Tablets — boxes of 96.
Dosage: SUSPENSION: 1 tablespoonful 20 minutes after meals and on retiring. May be taken with milk if desired. TABLETS: 2 or more tablets 20 minutes after meals and on retiring. May be chewed or allowed to dissolve slowly in the mouth.

MRT *M. R. Thompson, Inc.* CRANFORD, N. J.

now—for more comprehensive control of

'pain & spasm'

INDICATIONS

HEAD: temporomandibular muscle spasm • NECK: acute torticollis, osteoarthritis of cervical spine with spasm of cervical muscles, whiplash injury • TRUNK AND CHEST: costochondritis, intercostal myositis, xiphodynia • BACK: acute and chronic lumbar strains and sprains, acute low back pain (unspecified), acute lumbar arthritis and traumatic injury, compression fracture, herniated intervertebral disc, post-disc syndrome, strained muscle(s) • EXTREMITIES: acute hip injury with muscle spasm, ankle sprain, arthritis (as of foot or knee), blow to shin followed by muscle spasm, bursitis, spasm or strain of muscle or muscle group, old fracture with recurrent spasm, Pellegrini-Stieda disease, tenosynovitis with associated pain and spasm.

–pain due to or associated with –spasm of skeletal muscle

a new muscle relaxant-analgesic

Robaxisal®

ROBAXIN® WITH ASPIRIN

Many conditions, painful in themselves, often give rise to spasm of skeletal muscles. ROBAXISAL, the new dual-acting muscle relaxant-analgesic, treats both the pain and the spasm with marked success: In clinical studies on 311 patients, 12 investigators[1] reported satisfactory results in 86.5%. Each ROBAXISAL Tablet contains:

- A relaxant component — Robaxin — widely recognized for its prompt, long-lasting relief of painful skeletal muscle spasm, with unusual freedom from undesired side effects. 400 mg.

  [1] Methocarbamol Robins. U.S. Pat. No. 2770649

- An analgesic component — aspirin — whose pain-relieving effect is markedly enhanced by Robaxin, and which has added value as an anti-inflammatory and anti-rheumatic agent. (5 gr.) 325 mg.

INDICATIONS: ROBAXISAL is indicated when analgesic as well as relaxant action is desired in the treatment of skeletal muscle spasm and severe concurrent pain. Typical conditions are disorders of the back, whiplash and other traumatic injuries, myositis, and pain and spasm associated with arthritis.

SUPPLY: ROBAXISAL Tablets (pink-and-white, laminated) in bottles of 100 and 500.

Also available. ROBAXIN Injectable, 1.0 Gm. in 10-cc. ampul. ROBAXIN Tablets, 0.5 Gm. (white, scored) in bottles of 50 and 500.

[1] Clinical reports in files of A. H. Robins Co., Inc. from: J. Allen, Madison, Wisc.; B. Billow, New York, N. Y.; B. Decker, Richmond, Va.; C. Freeman, Jr., Augusta, Ga.; R. B. Gordon, New York, N. Y.; J. E. Holmblad, Schenectady, N. Y.; L. Levy, New York, N. Y.; N. LoBue, Chicago Heights, Ill.; H. Nachman, Richmond, Va.; A. Poindexter, Los Angeles, Cal.; E. Rogers, Brooklyn, N. Y.; K. H. Strong, Fairfield, Ia.

Additional information available upon request.

Robins

A. H. ROBINS CO., INC., Richmond 20, Virginia

Making today's medicines with integrity . . . seeking tomorrow's with persistence

chronic leg ulcer?

"many patients who had ulcers from one to eight years obtained complete healing in six to ten weeks."[1]

CHLORESIUM®

ointment

CHLORESIUM Ointment has long been recognized as a medication of choice for local treatment of chronic wounds and ulcerations.[1,2] This time-tested agent is noted for its ability to promote healthy granulation, encourage normal epithelization, relieve pain and inflammation, and deodorize malodorous lesions. Furthermore, a complete lack of irritating or sensitizing properties makes CHLORESIUM ideal for patient-use at home.

CHLORESIUM Ointment—0.5% water-soluble chlorophyll derivatives in a hydrophilic ointment base, in 1-oz. and 4-oz. tubes.

CHLORESIUM Solution—0.2% water-soluble chlorophyll derivatives in isotonic saline solution, in 2-oz. and 8-oz. bottles.

(1) Boehme, E. J.: Lahey Clin. Bull. 4:242, 1946. (2) Diamond, O. K.: New York J. Med. **59**:1792, 1959.

Samples and literature available on request

Rystan

Mount Vernon, N.Y.

34760

What's she doing that's of medical interest?

She's drinking a glass of pure Florida orange juice. And that's important to her physician for several reasons.

How your patients obtain their vitamins or any of the other nutrients found in citrus fruits is of great medical interest — considering the fact there are so many wrong ways of doing it, so many substitutes and imitations for the real thing.

Actually, there's no better way for this young lady to obtain her vitamin C than by doing just what she is doing, for there's no better source than oranges and grapefruit ripened in the Florida sunshine. There's no substitute for the result of nature's own mysterious chemistry, flourishing in the warmth of this luxurious peninsula.

An obvious truth, you might say, but not so obvious to the parents of many teen-agers.

We know that a tall glass of orange juice is just about the best thing they can reach for when they raid the refrigerator. We also know that if you encourage this refreshing and healthful habit, you'll be helping patients to the finest between-meals drink there is.

Nothing has ever matched the quality of Florida citrus — watched over as it is by a State Commission that enforces the world's highest standards for quality in fresh, frozen, canned or cartoned citrus fruits and juices.

That's why the young lady's activities are of medical interest.

© Florida Citrus Commission, Lakeland, Florida

Q. *When you want to reduce serum cholesterol and maintain it at a low level, is medication more realistic than dietary modifications?*

A. *Maintenance of lowered cholesterol concentration in the blood is a life-long problem. It is usually preferable, therefore, to try to obtain the desired results through simple dietary modification. This spares the patient added expense and permits him meals he will relish.*

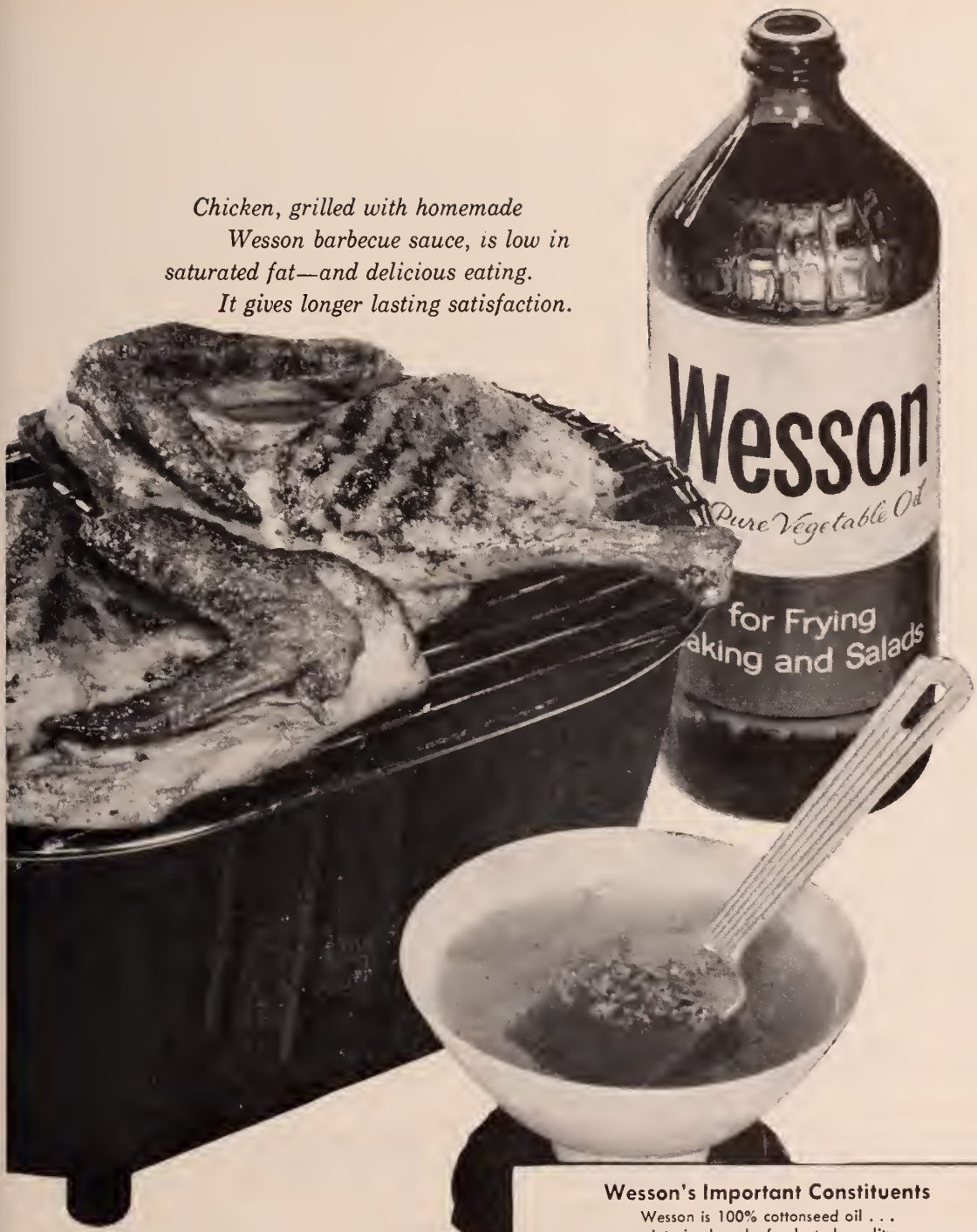
The modification is based on a diet to maintain optimum weight plus a judicious substitution of the poly-unsaturated oils for the saturated fats. One very simple part of the change is to cook the selected foods with poly-unsaturated Wesson. In the prescribed diet, this switch in type of fat will help to lower blood serum cholesterol and help maintain it at low levels. The use of Wesson permits a diet planned around many favorite and popular foods. Thus the patient finds it a pleasant, easy matter to adhere to the prescribed course.

Where a vegetable (salad) oil is medically recommended for a cholesterol depressant regimen, Wesson is unsurpassed by any readily available brand.

Uniformity you can depend on. Wesson has a poly-unsaturated content better than 50% . Only the lightest cottonseed oils of highest iodine number are selected for Wesson. No significant variations are permitted in the 22 exacting specifications required before bottling.

Wesson satisfies the most exacting appetites. To be effective, a diet must be *eaten* by the patient. The majority of housewives prefer Wesson particularly by the criteria of odor, flavor (blandness) and lightness of color. (Substantiated by sales leadership for 59 years and reconfirmed by recent tests against the next leading brand with brand identification removed, among a national probability sample.)

Chicken, grilled with homemade Wesson barbecue sauce, is low in saturated fat—and delicious eating. It gives longer lasting satisfaction.



FREE *Wesson recipes, available in quantity for your patients, show how to prepare meats, seafoods, vegetables, salads and desserts with poly-unsaturated vegetable oil. Request quantity needed from The Wesson People, Dept. N., 210 Baronne St., New Orleans 12, La.*

Wesson's Important Constituents

Wesson is 100% cottonseed oil . . . winterized and of selected quality

Linoleic acid glycerides (poly-unsaturated)	50-55%
Oleic acid glycerides (mono-unsaturated)	16-20%
Total unsaturated	70-75%
Palmitic, stearic and myristic glycerides (saturated)	25-30%
Phytosterol (predominantly beta sitosterol)	0.3-0.5%
Total tocopherols	0.09-0.12%

Never hydrogenated—completely salt free

Acts within minutes—KOAGAMIN, unlike other hemostatic agents, acts *quickly* in *minimal* dosages. Working on the late phases of the clotting mechanism, KOAGAMIN does not require massive and prolonged pre- or postoperative dosages to control capillary and venous bleeding.

Acts with predictable safety—In 20 years of clinical use, no toxic or side actions have been reported with KOAGAMIN. Bleeding is arrested without danger of thrombosis, and because KOAGAMIN contains no protein or alkaloid, it can be administered without danger of sensitization or untoward reactions.

Acts effectively in a broad range of indications—Because of its *unparalleled safety* and *outstanding effectiveness*, KOAGAMIN has been successfully employed in...hemorrhagic diseases, abnormal bleeding, blood disorders, surgical cases and trauma.

KOAGAMIN, an aqueous solution of oxalic (5 mg. per cc.) and malonic (2.5 mg. per cc.) acids for parenteral use, is supplied in 10-cc. diaphragm-stoppered vials.

CHATHAM PHARMACEUTICALS, INC · NEWARK 2, NEW JERSEY
Distributed in Canada by Austin Laboratories, Limited, Guelph, Ontario

Chatham

BEFORE, DURING AND AFTER SURGERY

KOAGAMIN®

(parenteral hemostat)

controls bleeding with minimal dosage and maximum safety

10360

Dimetane®†

distinguished by its
"...very low incidence of
undesirable side effects..."*

even in allergic infants

FROM A CLINICAL STUDY* IN ANNALS OF ALLERGY

Patients	200 infants and children, ages 2 months to 14 years
Diagnosis	Perennial allergic rhinitis
Therapy	Dimetane Elixir
Results	in 149, *good* results / in 40, *fair* results
Side Effects	Encountered in *only* 7 patients (in all except one, the side effect was mild drowsiness)

In allergic patients *of all ages,* Dimetane has been shown to work with an effectiveness rate of about 90% and to produce an exceptionally low incidence of side effects. Complete clinical data are available on request to the Medical Department. *Supplied:* DIMETANE Extentabs® (12 mg.), Tablets (4 mg.), Elixir (2 mg./5 cc.), new DIMETANE-TEN Injectable (10 mg./cc.) or new DIMETANE-100 Injectable (100 mg./cc.).

Robins

*MC COVERN, J. P., MC ELHENNEY, T. R., HALL, T. R., AND BURDON, K. O.: ANNALS OF ALLERGY 17:915, 1959.

A. H. ROBINS CO., INC., RICHMOND 20, VIRGINIA / ETHICAL PHARMACEUTICALS OF MERIT SINCE 1878

† PARABROMDYLAMINE MALEATE

adult stable diabetics and a significant number of sulfonylurea failures respond to

DBI

trademark,
brand of Phenformin HCl

broad-range oral hypoglycemic-hypoglycosuric agent

not a sulfonylurea

adult stable diabetes

"In our experience the action of DBI on the adult stable type of diabetes is impressive **...88% were well controlled by DBI."**[1]

"Most mild diabetic patients were well controlled on a biguanide compound [DBI], and such control was occasionally superior to that of insulin. This was true regardless of age, duration of diabetes, or response to tolbutamide."[2]

"DBI has been able to replace insulin or other hypoglycemic agents with desirable regulation of the diabetes when it is used in conjunction with diet in the management of adult and otherwise stable diabetes."[3]

sulfonylurea failures

Among those diabetics who responded to tolbutamide initially and became secondary failures **DBI "gave a satisfactory response in 55%."**[4]

"DBI is capable of restoring control in a considerable portion of patients in whom sulfonylurea compounds have failed, either primarily or secondarily."[5]

"All twelve secondary tolbutamide failures have done well on DBI."[6]

"34 out of 59 sulfonylurea primary failures were successfully treated with DBI."[7]

DBI

lowers blood sugar in mild, moderate and severe diabetes, in children and adults

DBI (N^1-β-phenethylbiguanide HCl) is available as white, scored tablets of 25 mg. each, bottles of 100.

Send for brochure with complete dosage instructions for each class of diabetes, and other pertinent information.

1. Walker, R. S.: Brit. M. J. 2:405, 1959.
2. Odell, W. D., et al.: A.M.A. Arch. Int. Med. 102:520, 1958.
3. Pearlman, W.: Phenformin Symposium, Houston, Feb. 1959.
4. DeLawter, D. E., et al.: J.A.M.A. 171:1786 (Nov. 28) 1959.
5. McKendry, J. B., et al.: Canad. M. A. J. 80:773, 1959.
6. Miller, E. C.: Phenformin Symposium, Houston, Feb. 1959.
7. Krall, L. P.: Applied Therapeutics 2:137, 1960.

an original development from the research laboratories of

u. s. vitamin & pharmaceutical corporation

Arlington-Funk Laboratories, division

250 East 43rd Street, New York 17, N.Y.

Lifts depression..

You see an improvement within a few days
Thanks to your prompt treatment and the smooth action of Deprol, her depression is relieved and her anxiety and tension calmed – *often in a few days.* She eats well, sleeps well and soon returns to her normal activities.

as it calms anxiety!

Smooth, balanced action lifts depression as it calms anxiety... rapidly and safely

Balances the mood — no "seesaw" effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient —*they often aggravate anxiety and tension.*

And although amphetamine-barbiturate combinations may counteract excessive stimulation—*they often deepen depression.*

In contrast to such "seesaw" effects, Deprol's smooth, *balanced* action lifts depression as it calms anxiety—both at the same time.

Acts swiftly — the patient often feels better, sleeps better, within a few days. Unlike the delayed action of most other antidepressant drugs, which may take two to six weeks to bring results, Deprol relieves the patient quickly — often within a few days. Thus, the expense to the patient of long-term drug therapy can be avoided.

Acts safely — no danger of liver damage. Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function—frequently reported with other antidepressant drugs.

Bibliography *(13 clinical studies, 858 patients)*: **1.** Alexander, L. (35 patients): Chematherapy of depression — Use of meprabamate cambined with benactyzine (2-diethylaminaethyl benzilate) hydrachloride. J.A.M.A. 166:1019, March 1, 1958. **2.** Bateman, J. C. and Carltan, H. N. (50 patients): Meprabamate and benactyzine hydrachloride (Depral) as adjunctive therapy far patients with advanced cancer. Antibiotic Med. & Clin. Therapy 6:648, Nav. 1959. **3.** Beerman, H. M. (44 patients): The treatment af depressian with meprobamate and benactyzine hydrachlaride. Western Med. 1:10, March 1960. **4.** Bell, J. L., Tauber, H., Santy, A. and Pulita, F. (77 patients): Treatment af depressive states in affice practice. Dis. Nerv. System 20:263, June 1959. **5.** Breitner, C. (31 patients): On mental depressians. Dis. Nerv. System 20:142, (Sectian Twa), May 1959. **6.** Gardan, P. E. (50 patients): Depral in the treatment of depressian. Dis. Nerv. System 21:215, April 1960. **7.** Landman, M. E. (50 patients): Clinical trial af a new antidepressive agent. J. M. Sac. New Jersey. In press, 1960. **8.** McClure, C. W., Papas, P. N., Speare, G. S., Palmer, E., Slattery, J. J., Kanefal, S. H., Henken, B. S., Waad, C. A. and Ceresia, G. B. (128 patients): Treatment af depressian — New technics and therapy. Am. Pract. & Digest Treat. 10:1525, Sept. 1959. **9.** Penningtan, V. M. (135 patients): Meprabamate-benactyzine (Depral) in the treatment af chranic brain syndrame, schizaphrenia and senility. J. Am. Geriatrics Sac. 7:656, Aug. 1959. **10.** Rickels, K. and Ewing, J. H. (35 patients): Depral in depressive conditians. Dis. Nerv. System 20:364, (Sectian One), Aug. 1959. **11.** Ruchwarger, A. (87 patients): Use af Depral (meprabamate cambined with benactyzine hydrachlaride) in the affice treatment af depressian. M. Ann. District af Calumbia 28:438, Aug. 1959. **12.** Settel, E. (52 patients): Treatment af depressian in the elderly with a meprabamate-benactyzine hydrachlaride cambinatian. Antibiatic Med. & Clin. Therapy 7:28, Jan. 1960. **13.** Splitter, S. R. (84 patients): Treatment of the anxiaus patient in general practice. J. Clin. & Exper. Psychapath. In press, April-June 1960.

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

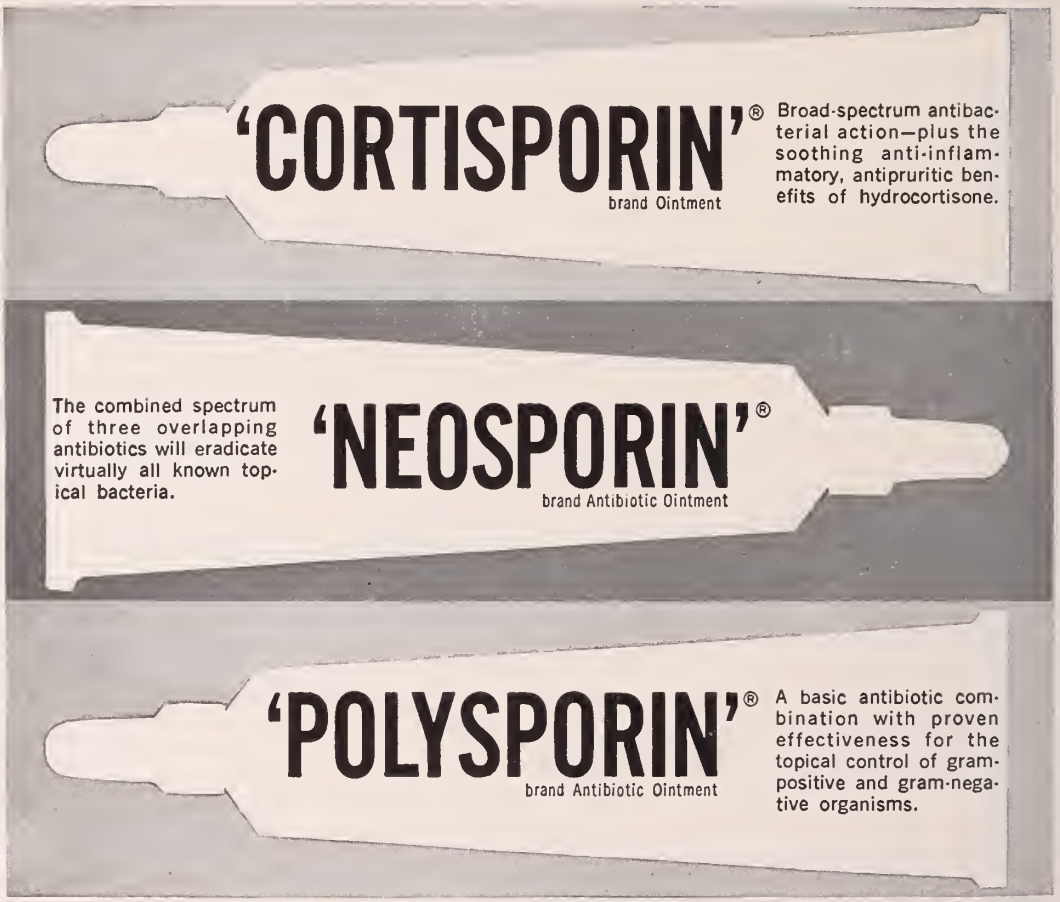
Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate.
Supplied: Bottles of 50 light-pink, scored tablets. Write for literature and samples.

Deprol®

WALLACE LABORATORIES / *New Brunswick, N. J.*

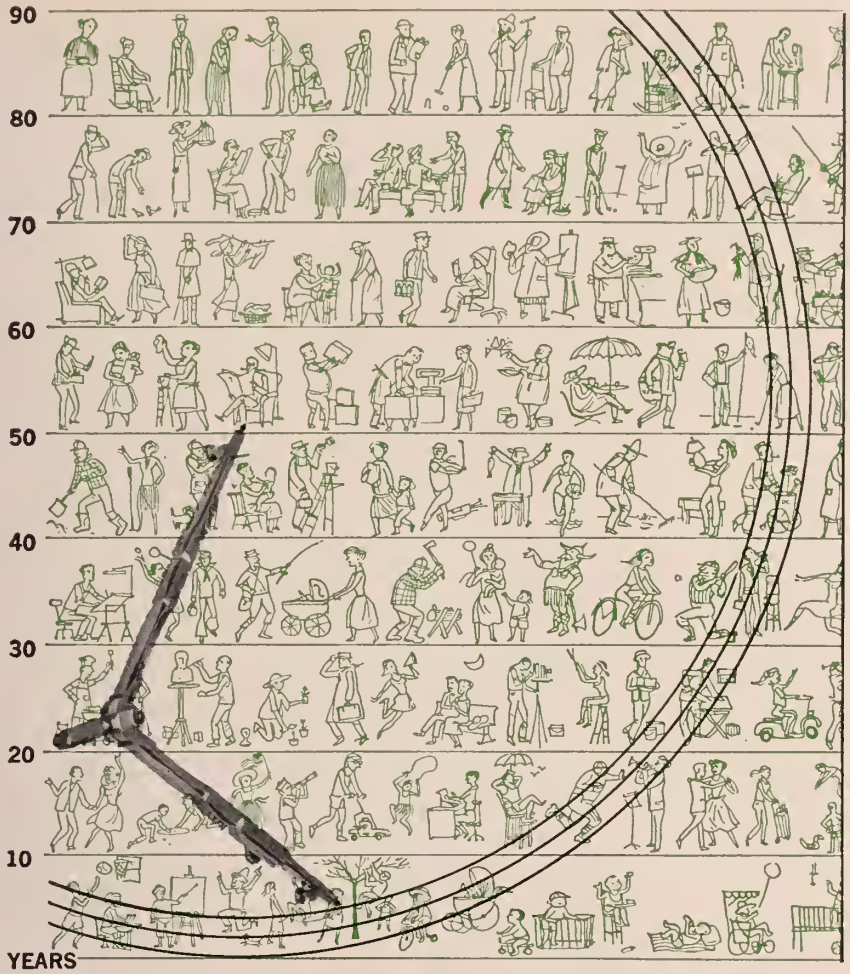
CO-2128

'B. W. & Co.' 'Sporin' Ointments rarely sensitize . . . give decisive bactericidal action for most every topical indication



Contents per Gm.	'Polysporin'®	'Neosporin'®	'Cortisporin'®
'Aerosporin'® brand Polymyxin B Sulfate	10,000 Units	5,000 Units	5,000 Units
Zinc Bacitracin	500 Units	400 Units	400 Units
Neomycin Sulfate	—	5 mg.	5 mg.
Hydrocortisone	—	—	10 mg.
Supplied:	Tubes of 1 oz., ½ oz. and ⅛ oz. (with ophthalmic tip)	Tubes of 1 oz., ½ oz. and ⅛ oz. (with ophthalmic tip)	Tubes of ½ oz. and ⅛ oz. (with ophthalmic tip)

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, New York



senile anxiety
disorientation
agitation
hostility
irritability
apprehension
hysteria
insomnia
chronic urticaria
alcoholism
menopausal syndrome
neuro-dermatoses
functional gastrointestinal disorders
psychoneuroses
tension headaches
dysmenorrhea
psychosomatic complaints
situational stress
asthma
hyperactivity
tics
preoperative anxiety
enuresis
behavior problems

ATARAX ENCOMPASSES MORE PATIENT NEEDS...LETS YOU CHART A SAFER, MORE EFFECTIVE COURSE TO TRANQUILITY

ATARAX has a wide range of flexibility . . . from mild adult tensions and anxieties to full-blown alcoholic episodes . . . from the behavior disorders of childhood to the emotional problems of old age. Why? Because it gives you maximum adaptability of dosage . . . works quickly and predictably . . . is unsurpassed in safety.

ATARAX offers extra pharmacologic actions especially useful in certain troublesome conditions. It is antihistaminic and mildly antiarrhythmic, does not stimulate gastric secretions. Hence it is well suited to the needs of your allergic, cardiac and ulcer patients.

Have you discovered all the benefits of ATARAX?

Dosage: Adults, one 25 mg. tablet, or one tbsp. Syrup q.i.d. Children, 3-6 years, one 10 mg. tablet or one tsp. Syrup t.i.d.; over 6 years, two 10 mg. tablets or two tsp. Syrup t.i.d.

Supplied: Tiny 10 mg., 25 mg., and 100 mg. tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution: 25 mg./cc. in 10 cc. multiple-dose vials; 50 mg./cc. in 2 cc. ampules. Prescription only.

Complete bibliography available on request.

ATARAX®

(BRAND OF HYDROXYZINE)

PASSPORT TO TRANQUILITY

Pfizer

New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being™

VITERRA® for vitamin-mineral supplementation
• capsules • tastitabs®
• therapeutic capsules

Keep Spirits Up as WEIGHT GOES DOWN..

OBETROL®

Patent #2748052

for medical management of obesity

The **different** amphetamine combination of choice... even in many cases of hyperthyroidism, hypertension, coronary artery and other cardiovascular diseases.

- Safer
- Allays hunger
- Diuretic action
- Elevates mood
- Fewer contraindications
- Potent and effective

OBETROL incorporates the desired action of amphetamines without usual drawbacks.

OBETROL Each 20 mg. tablet or two 10 mg. tablets contain safer, longer acting Methamphetamine Saccharate 5 mg., with Methamphetamine Hydrochloride 5 mg., Amphetamine Sulfate 5 mg., Dextro Amphetamine Sulfate 5 mg.

SUPPLIED: in 10 mg. and 20 mg. tablets in bottles of 100, 500, and 1,000.

Ref: Plotz, M.: Modern Management of Obesity, J.A.M.A. 170: 1513-1515 (July 25) 1959.

Available on prescription at all leading pharmacies.

Write today for clinical samples.

REFER TO PDR Page 753

OBETROL PHARMACEUTICALS • 382 Schenck Avenue • Brooklyn 7, N. Y.

Doctors, too, like "Premarin"®

THE doctor's room in the hospital is used for a variety of reasons. Most any morning, you will find the internist talking with the surgeon, the resident discussing a case with the gynecologist, or the pediatrician in for a cigarette. It's sort of a club, this room, and it's a good place to get the low-down on "Premarin" therapy.

If you listen, you'll learn not only that doctors like "Premarin," but *why* they like it.

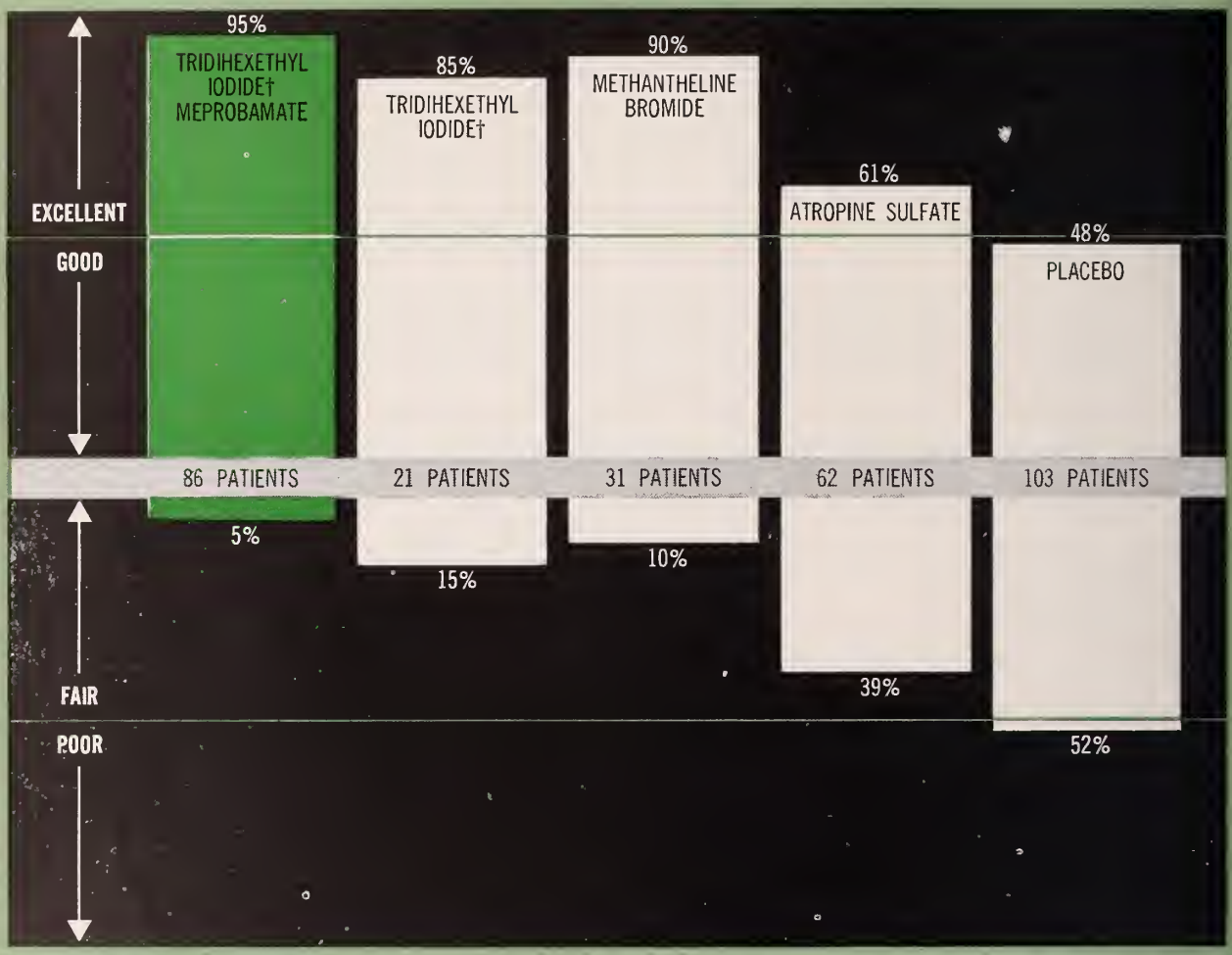
The reasons are fairly simple. Doctors like "Premarin," in the first place, because it really relieves the symptoms of the menopause. It doesn't just mask them — it replaces what the patient lacks — natural estrogen. Furthermore, if the patient is suffering from headache, insomnia, and arthritic-like symptoms due to estrogen deficiency, "Premarin" takes care of that, too.

"Premarin," conjugated estrogens (equine), is available as tablets and liquid, and also in combination with meprobamate or methyltestosterone.

Ayerst Laboratories • New York 16, N. Y. • Montreal, Canada

clinically proven efficacy.

in relieving tension . . . curbing hypermotility and excessive secretion in G. I. disorders



PATHIBAMATE combines two highly effective and well-tolerated therapeutic agents:

Meprobamate—widely accepted tranquilizer and

PATHILON tridihexethyl chloride—anticholinergic noted for its effect on motility and gastrointestinal secretion with few unwanted side effects.

Contraindications: glaucoma, pyloric obstruction, and obstruction of the urinary bladder neck.

Two available dosage strengths permit adjusting therapy to the G.I. disorder and degree of associated tension.

Where a minimal meprobamate effect is preferred . . .
PATHIBAMATE-200 Tablets: 200 mg. of meprobamate; 25 mg. of PATHILON

Where a full meprobamate effect is preferred . . .
PATHIBAMATE-400 Tablets: 400 mg. of meprobamate; 25 mg. of PATHILON

Dosage: Average oral adult dose is 1 tablet t.i.d. at mealtime and 2 tablets at bedtime.

Pathibamate® 400 200

meprobamate with PATHILON® tridihexethyl chloride Lederle

clinically proven safety

The efficacy of **PATHIBAMATE** has been confirmed clinically in **duodenal ulcer, gastric ulcer, intestinal colic, spastic and irritable colon, ileitis, esophageal spasm, anxiety neurosis** with gastrointestinal symptoms, and **gastric hypermotility.**

Pictured are the results obtained with the PATHILON (tridihexethyl iodide)–meprobamate combination† in a double-blind study of 303 ulcer patients, extending over a period of 36 months.* They clearly demonstrate the efficacy of **PATHIBAMATE** in controlling the symptoms.

SIDE EFFECTS	TRIDIHEXETHYL IODIDE† MEPROBAMATE	TRIDIHEXETHYL IODIDE†	METHANTHELINE BROMIDE	ATROPINE SULFATE	PLACEBO
DRY MOUTH	1%	5%	72%	46%	5%
STOMATITIS	1%	0%	28%	14%	0%
VISUAL DISTURBANCES	0%	0%	50%	34%	1%
URINARY RETENTION	0%	0%	18%	11%	1%
DROWSINESS	20%	0%	0%	0%	0%
COMPLICATIONS OR SURGERY					
HEMORRHAGE	0%	9%	3%	9%	10%
PERFORATION	0%	0%	0%	6%	0%
OPERATION	0%	5%	5%	14%	2%
RECURRENCES					
NONE	28%	23%	25%	17%	26%
FEWER AND MILDER	67%	62%	52%	37%	24%
SAME OR MORE	5%	15%	23%	46%	50%

*Atwater, J. S., and Carson, J. M.: Therapeutic Principles in Management of Peptic Ulcer. Am. J. Digest. Dis. 4:1055 (Dec.) 1959.

†PATHILON is now supplied as tridihexethyl chloride instead of the iodide, an advantage permitting wider use, since the latter could distort the results of certain thyroid function tests.

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

control the tension — treat the trauma

STEREO WEBCOR

WEBCOR REGENT CORONET STEREO HI-FI TAPE RECORDER **$329.95**

- Will record and play back both stereo and monaural tapes
- Provides 2-channel and 4-channel stereo playback
- Dual-channel 16-watt amplifier
- Self-contained Stereo system with 2 Hi-Fi Speakers
- 2 directional microphones
- In ebony with silver trim

Model 2007

Available at all

DEPT. STORES AND BETTER MUSIC, RECORD, CAMERA AND APPLIANCE DEALERS

Write for catalog to Exclusive N. J. Wholesale Distributors

ALL-STATE DISTRIBUTORS,

INCORPORATED

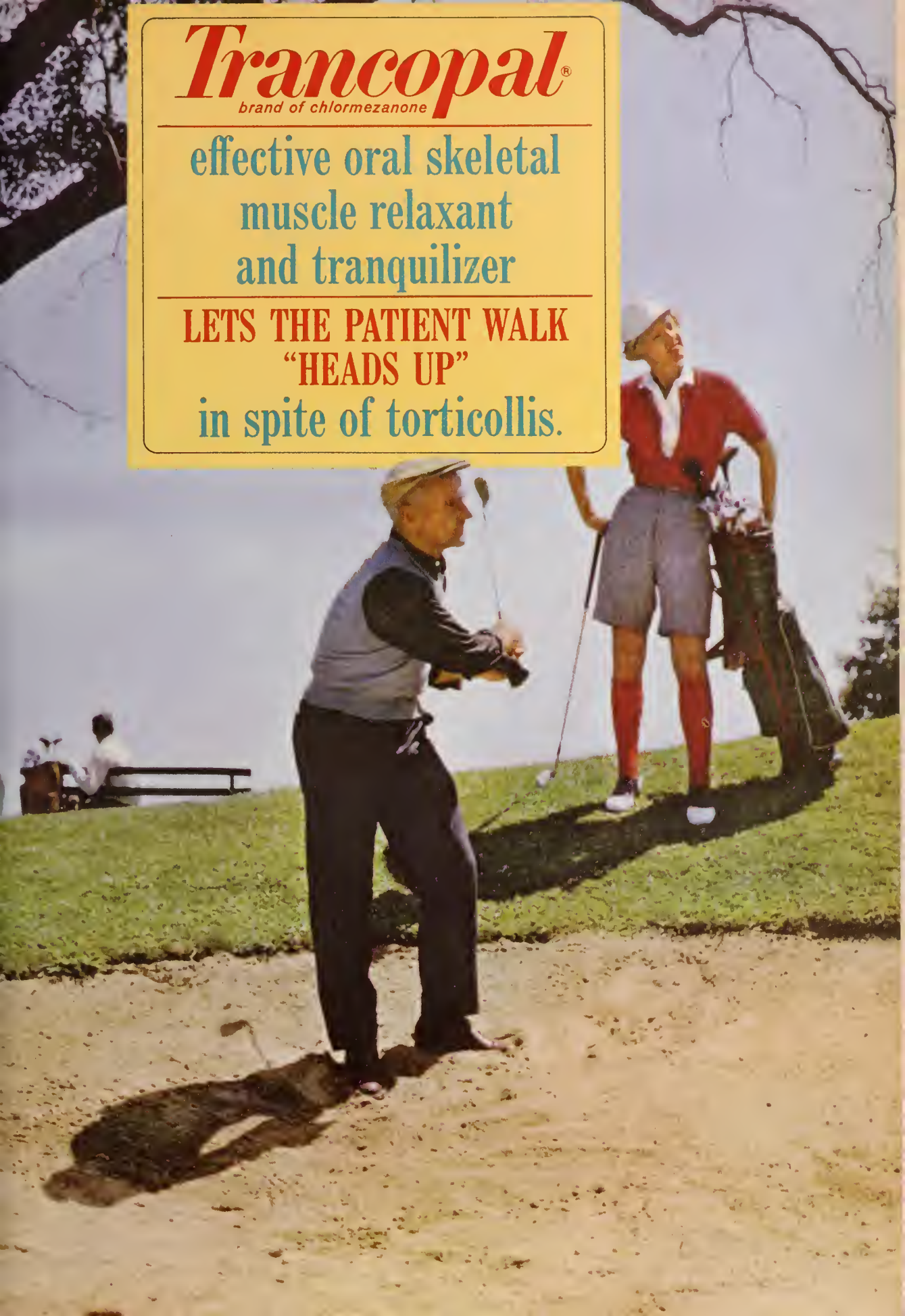
457 CHANCELLOR AVENUE - WAverly 3-4900 - NEWARK, N. J.

Trancopal®

brand of chlormezanone

effective oral skeletal muscle relaxant and tranquilizer

LETS THE PATIENT WALK "HEADS UP" in spite of torticollis.



Trancopal

relieves pain and spasm associated with torticollis.

In a recent study by Ganz, Trancopal brought considerable improvement or very effective relief to 20 of 29 patients with torticollis.[1] "The patients helped by the drug," states Ganz, "were able to carry the head in the normal position without pain." Similarly, Kearney found that in 8 of 13 patients with chronic torticollis treated with Trancopal improvement was excellent to good. ". . . Trancopal is the most effective oral skeletal muscle relaxant and mild tranquilizer currently available."[2]

Lichtman, in a study of patients with various musculoskeletal conditions, noted that 64 of 70 patients with torticollis obtained excellent to good relief with Trancopal.[3]

In a comparative study of four central nervous system relaxants, Lichtman reports that 26 of 40 patients found Trancopal to be the most effective drug.[3]

1. Ganz, S. E.: *J. Indiana* 52:1134, July, 1959. 2. Kearney, *Current Therap. Res.* 2:127, 1960. 3. Lichtman, A. L.: *Ken Acad. Gen. Pract. J.* 4:28, Oct.,

Trancopal (brand of chlormezanone) and Caplets, trademarks reg. U. S. Pat. Off. 4716

Clinical results with *Trancopal*®[2]

	Excellent	Good	Fair	Poor	Total
LOW BACK SYNDROMES					
Acute low back strain	25	19	8	6	58
Chronic low back strain	11	5	1	1	18
"Porters' syndrome"*	21	5	1	1	28
Pelvic fractures	2	1	—	—	3
NECK SYNDROMES					
Whiplash injuries	12	6	2	1	21
Torticollis, chronic	6	2	3	2	13
OTHER MUSCLE SPASM					
Spasm related to trauma	15	6	1	—	22
Rheumatoid arthritis	—	18	2	1	21
Bursitis	2	6	1	—	9
TENSION STATES	18	2	4	3	27
TOTALS	112 (51%)	70 (32%)	23 (10%)	15 (7%)	220 (100%

*Over-reaching in lifting heavy bags resulting in sprain of upper, middle, and lower back muscles.

Dosage: **Adults, 200 or 100 mg. orally three or four times daily.**
Relief of symptoms occurs in from fifteen to thirty minutes and lasts from four to six hours.

How Supplied: Trancopal Caplets®
200 mg. (green colored, scored), bottles of 100.
100 mg. (peach colored, scored), bottles of 100.

Winthrop LABORATORIES, New York 18, N. Y.

AN AMES CLINIQUICK®

CLINICAL BRIEFS FOR MODERN PRACTICE

WHAT LABORATORY PROCEDURES ARE INDICATED IN DIABETICS WITH URINARY TRACT INFECTIONS?

A urine culture is absolutely essential in the diabetic suspected of having a urinary tract infection since such infection is not always accompanied by pyuria. It is also essential to keep the urine free from sugar—as shown by frequent urine-sugar tests—for successful therapy.

Source: Harrison, T. R., *et al.*: Principles of Internal Medicine, ed. 3, New York, McGraw-Hill Book Co., 1958, p. 620.

the most effective method of routine testing for glycosuria...
color-calibrated

CLINITEST®

BRAND *Reagent Tablets*

the *standardized* urine-sugar test for reliable quantitative estimations

Urinary tract infections are about four times more frequent in the diabetic than in the non-diabetic. The prevention and treatment of urinary tract infections, as well as the avoidance of other complications of diabetes, are significantly more effective in the well-controlled diabetic. The patient should be impressed repeatedly with the importance of continued daily urine-sugar testing—especially during intercurrent illness—and warned of the consequences of relaxed vigilance.

"urine-sugar profile" With the new *Graphic Analysis Record* included in the CLINITEST Urine-Sugar Analysis Set (and in the tablet refills), daily urine-sugar readings may be recorded to form a graphic portrayal of glucose excretion most useful in clinical control.

- *motivates patient cooperation* through everyday use of Analysis Record
- *reveals at a glance day-to-day trends* and degree of control
- *provides a standardized color scale* with a complete range in the familiar blue-to orange spectrum

84460

AMES
COMPANY, INC
Elkhart • Indiana
Toronto • Canada

guard against ketoacidosis
...test for ketonuria
for patient and physician use

ADDED SAFETY FOR DIABETIC CHILDREN

ACETEST® *Reagent Tablets*

KETOSTIX® *Reagent Strips*

when sulfa is your plan of therapy...

KYNEX®

Sulfamethoxypyridazine Lederle

OUTSTANDING 1-DOSE-A-DAY SULFA

Rapid peak attainment in 1 to 2 hours[1,2] . . . approximately one-half the time of other single-daily dose sulfas.[2] *High free levels*—as much as 95 per cent of circulating levels remaining in fully active unconjugated forms.[3] *Extremely low 2.7 per cent incidence of side effects* in toxicity studies on 223 patients.[4] Includes *total* reactions (subjective and objective), all temporary and rapidly reversed. No crystalluria reported.

KYNEX TABLETS, 0.5 Gm., bottles of 24 and 100. Dosage: Adults, 0.5 Gm. (1 tablet) daily following an initial first day dose of 1 Gm. (2 tablets).

KYNEX ACETYL PEDIATRIC SUSPENSION, cherry-flavored, 250 mg. sulfamethoxypyridazine activity per tsp. (5 cc.). Bottles of 4 and 16 fl. oz.

New **KYNEX** ACETYL PEDIATRIC DROPS, cherry-flavored, 125 mg. sulfamethoxypyridazine activity per cc. In 10 cc. squeeze bottle.

New for acute G. U. infection **AZO KYNEX** TABLETS (for q. i. d. dosage), 125 mg., **KYNEX** Sulfamethoxypyridazine in the shell with 150 mg. phenylazodiaminopyridine HCl in the core.

Precautions: Usual sulfonamide precautions apply.

1. Boger, W. P.; Strickland, C. S., and Gylfe, J. M.: *Antibiotic Med. & Clin. Ther.* 3:378 (Nov.) 1956. 2. Boger, W. P.: In: *Antibiotics Annual* 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 48. 3. Sheth, U. K.; Kulkarni, B. S., and Kamath, P. G.: *Antibiotic Med. & Clin. Ther.* 5:604 (Oct.) 1958. 4. Anderson, P. C., and Wissinger, H. A.: *U. S. Armed Forces M. J.* 10:1051 (Sept.) 1959.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle

WHEN ULCEROGENIC FACTORS KEEP ON WORKING...

REMEMBER THIS: SO DOES ENARAX

Think of your patient with peptic ulcer—or with gastrointestinal dysfunction—on a typical day.

Think of the anxieties, the tensions.

Think, too, of the night: the state of his stomach emptied of food.

Disturbing?

Then think of ENARAX. For ENARAX was formulated to help you control precisely this clinical picture. ENARAX provides oxyphencyclimine, the inherently long-acting anticholinergic (up to 9 hours of actual achlorhydria[1]) . . . plus Atarax, the tranquilizer that doesn't stimulate gastric secretion.

Thus, with b.i.d. dosage, you provide continuous antisecretory/antispasmodic action and safely alleviate anxiety . . . with these results: ENARAX has been proved effective in 92% of G.I. patients.[2-4]

When ulcerogenic factors seem to work against you, let ENARAX work for you.

ENARAX® B.I.D.

(10 MG. OXYPHENCYCLIMINE PLUS 25 MG. ATARAX®†) A SENTRY FOR THE G.I. TRACT

dosage: Begin with one-half tablet b.i.d.—preferably in the morning and before retiring. Increase dosage to one tablet b.i.d. if necessary, and adjust maintenance dose according to therapeutic response. Use with caution in patients with prostatic hypertrophy and only with ophthalmological supervision in glaucoma.

supplied: In bottles of 60 black-and-white scored tablets. Prescription only.

References: 1. Steigmann, F., et al.: Am. J. Gastroenterol. **33**:109 (Jan.) 1960. 2. Hock, C. W.: to be published. 3. Leming, B. H., Jr.: Clin. Med. **6**:423 (Mar.) 1959. 4. Data in Roerig Medical Department Files.

†brand of hydroxyzine

FOR HEMATOPOIETIC STIMULATION WHERE OCCULT BLEEDING IS PRESENT

HEPTUNA® PLUS

THE COMPLETE ANEMIA THERAPY

New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being™

whenever depression complicates the picture

Tofrānil®

brand of imipramine HCl

hastens recovery

Geigy

In many seemingly mild physical disorders an element of depression plays an insidious etiologic or complicating role.

Because of its efficacy as an antidepressant, coupled with its simplicity of usage, Tofrānil is admirably adapted to use in the home or office in these milder "depression-complicated" cases.

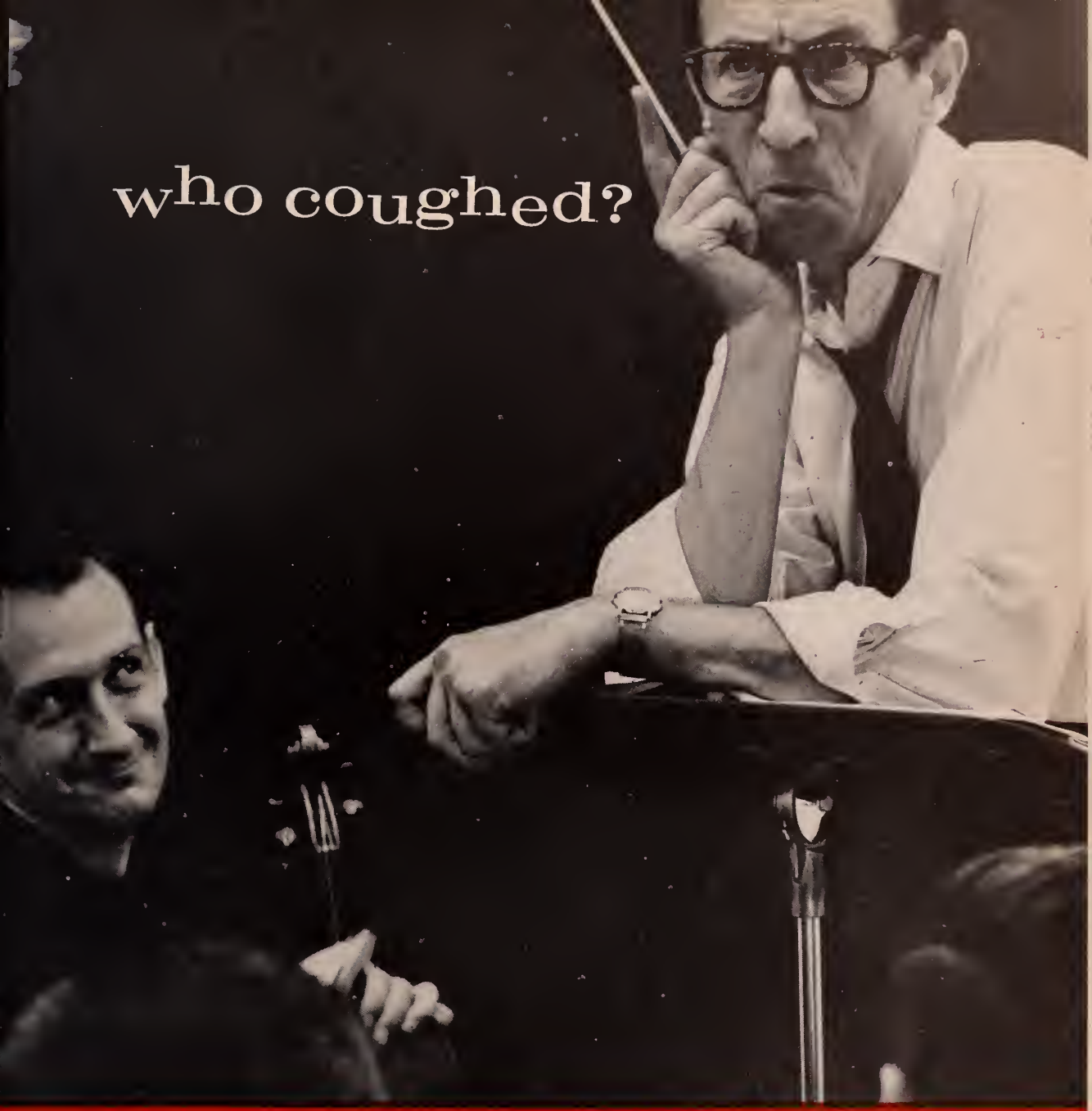
It is always wise to recognize that depression may be an underlying factor...that Tofrānil may speed recovery in "hypochondriasis"; in convalescence when recovery is inexplicably prolonged; in chronic illness with dejection; in the menopausal patient whose emotional disturbances resist hormone therapy; and in many other comparable situations in which latent depression may play a part.

Detailed Literature Available on Request.

Tofrānil®, brand of imipramine hydrochloride, tablets of 25 mg. Ampuls for intramuscular administration, 25 mg. in 2 cc. of solution.

Geigy, Ardsley, New York

160-60



WHENEVER COUGH THERAPY IS INDICATED

HYCOMINE® Syrup

THE COMPLETE Rx FOR COUGH CONTROL

cough sedative / antihistamine decongestant / expectorant

■ relieves cough and associated symptoms in 15-20 minutes ■ effective for 6 hours or longer ■ promotes expectoration ■ rarely constipates ■ agreeably cherry-flavored.

Each teaspoonful (5 cc.) of HYCOMINE* Syrup contains:

Hycodan®	
Dihydrocodeinone Bitartrate . . . . . 5 mg. (Warning: May be habit-forming)	6.5 mg.
Homatropine Methylbromide . . . . . 1.5 mg.	
Pyrilamine Maleate	12.5 mg.
Phenylephrine Hydrochloride	10 mg.
Ammonium Chloride	60 mg.
Sodium Citrate	85 mg.

Average adult dose: One teaspoonful after meals and at bedtime. May be habit-forming. Federal law permits oral prescription.

Endo®

Literature on request

ENDO LABORATORIES
Richmond Hill 18, New York

*U.S. Pat. 2,630,400

CLINICAL REMISSION IN A "PROBLEM" ARTHRITIC

In rheumatoid arthritis with serious corticoid side effects. Following profound weight loss and acute g.i. distress on prednisolone, a 45-year-old bookkeeper with a five-year history of severe arthritis was started on DECADRON, 1 mg./day. Dosage was promptly reduced to 0.5 mg./day. After ten months on DECADRON, she gained back eleven pounds, feels very well, and had no recurrence of stomach symptoms. She is in clinical remission.*

New convenient b.i.d. alternate dosage schedule: the degree and extent of relief provided by DECADRON allows for b.i.d. maintenance dosage in many patients with so-called "chronic" conditions. Acute manifestations should first be brought under control with a t.i.d. or q.i.d. schedule.

Supplied: As 0.75 mg. and 0.5 mg. scored, pentagon-shaped tablets in bottles of 100. Also available as Injection DECADRON Phosphate. Additional information on DECADRON is available to physicians on request. DECADRON is a trademark of Merck & Co., Inc.

*From a clinical investigator's report to Merck Sharp & Dohme.

Decadron®

Dexamethasone

TREATS MORE PATIENTS MORE EFFECTIVELY

MSD MERCK SHARP & DOHME • Division of Merck & Co., Inc., West Point, Pa.

1,928 published cases in the two years since TAO was released for general use show:

94.3% effectiveness in respiratory infections (617 cases including tonsillitis, staphylococcal and streptococcal pharyngitis, bronchitis, infectious asthma, broncho-pneumonia, lobar pneumonia, bronchiectasis, lung abscess, otitis.) **You can count on TAO.**

92% effectiveness in skin and soft tissue infections (900 cases including pyoderma, impetigo, acne, infected skin disorders, wounds, incisions and burns, furunculosis, abscess, cellulitis, chronic ulcer, adenitis.) **You can count on TAO.**

87.1% effectiveness in genitourinary infections (349 cases including urethritis, cystitis, pyelitis, pyelonephritis, orchitis, pelvic inflammation, acute gonococcal urethritis, lymphogranuloma venereum.) **You can count on TAO.**

75.8% effectiveness in diverse infections (62 cases including fever of undetermined origin, peritoneal abscess, osteitis, periarthritis, septic arthritis, staphylococcal enterocolitis, gastroenteritis, carriers of staphylococci.) **You can count on TAO.**

95.6% of 1,928 cases free of side effects—in the remaining 4.4%, reactions were chiefly mild gastrointestinal disturbances which seldom necessitated discontinuance of therapy.

*In 884 of 1,928 cases the causative organisms were mostly staphylococci. The majority of clinical isolates were found to be resistant to at least one of the commonly used antibiotics and many patients had failed to respond to previous therapy with one or more antibiotics. **TAO proved 93.4% effective in these 884 cases.**

Complete bibliography available on request.

DOSAGE: varies according to severity of infection. Usual adult dose—250 to 500 mg. q.i.d. Usual pediatric dose: 3·5 mg./lb. body weight every 6 hours.

NOTE: In some children, when TAO was administered at considerably higher than therapeutic levels for extended periods, transient-jaundice and other indications of liver dysfunction have been noted. A rapid and complete return to normal occurred when TAO was withdrawn.

SUPPLY: TAO CAPSULES—250 mg. and 125 mg., bottles of 60. TAO ORAL SUSPENSION—125 mg. per 5 cc. when reconstituted, palatable cherry flavor, 60 cc. bottles. TAO PEDIATRIC DROPS—100 mg. per cc. when reconstituted, flavorful; special calibrated dropper, 10 cc. bottles. INTRAMUSCULAR or INTRAVENOUS—10 cc. vials, as oleandomycin phosphate.

OTHER TAO FORMULATIONS ALSO AVAILABLE: TAO®-AC (Tao, analgesic, antihistaminic compound) capsules, bottles of 36. TAOMID® (Tao with Triple Sulfas)—tablets, bottles of 60. Oral Suspension—60 cc. bottles.

For nutritional support **VITERRA®** Vitamins and Minerals
Formulated from Pfizer's line of fine pharmaceutical products.

ROERIG
New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being™

1¼ Grs. Ea.
FLAVORED

Living up to a family tradition

There are probably certain medications which are special favorites of yours, medications in which you have a particular confidence.

Physicians, through ever increasing recommendation, have long demonstrated their confidence in the uniformity, potency and purity of Bayer Aspirin, the world's first aspirin.

And like Bayer Aspirin, Bayer Aspirin for Children is quality controlled. No other maker submits aspirin to such thorough quality controls as does Bayer. This assures uniform excellence in both forms of Bayer Aspirin.

You can depend on Bayer Aspirin for Children for it has been conscientiously formulated to be the best tasting aspirin ever made and to live up to the Bayer family tradition of providing the finest aspirin the world has ever known.

Bayer Aspirin for Children—1¼ grain flavored tablets—Supplied in bottles of 50.

● We welcome your requests for samples on Bayer Aspirin and Flavored Bayer Aspirin for Children.

New GRIP-TIGHT CAP for Children's Greater Protection

THE BAYER COMPANY, DIVISION OF STERLING DRUG INC., 1450 BROADWAY, NEW YORK 18, N. Y.

SALUTENSIN™

Hydroflumethiazide • Reserpine • Protoveratrine A

An integrated multi-therapeutic antihypertensive, that combines in balanced proportions three clinically proven antihypertensives.

In each **SALUTENSIN** Tablet:

Saluron® (hydroflumethiazide)—
a saluretic-antihypertensive ..... 50 mg.

Reserpine—a tranquilizing drug with
peripheral vasorelaxant effects ..... 0.125 mg.

Protoveratrine A—a centrally mediated
vasorelaxant ..... 0.2 mg.

Comprehensive information on dosage and precautions in official package circular or available on request.

BRISTOL LABORATORIES • Syracuse, New York

basic in the care of the aging

℞ Metalex®

when body tone, mental and sensory faculties begin to fade—*she's irritable, confused, forgetful, apathetic*

when vision begins to dim—*in loss of visual acuity, in loss of peripheral vision*

when voices begin to fade—*in loss of auditory acuity, in tinnitus*

Metalex® *cerebral stimulant/vasodilator*

The stimulant—pentylenetetrazol—facilitates cerebral and reflex nerve activity.

The vasodilator—nicotinic acid—augments blood and oxygen supply to vital areas—

Thus, METALEX increases body tone and aids mental and sensory faculties.

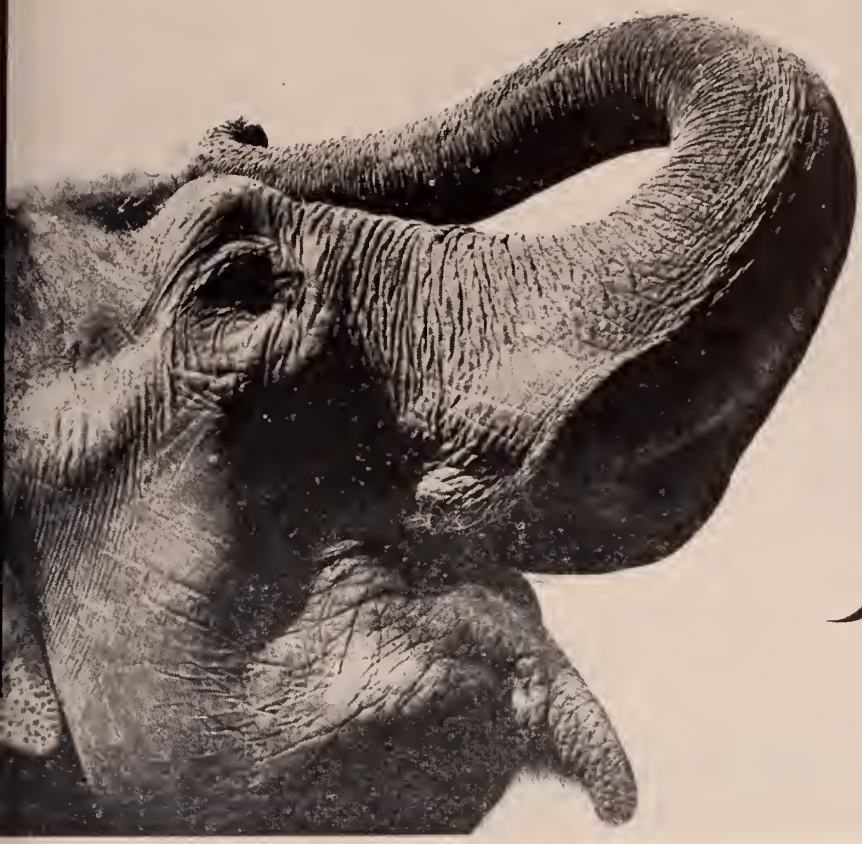
Composition: Each teaspoonful (5 ml.) of the Elixir and each Tablet contains: Pentylenetetrazol 100 mg., Nicotinic Acid 50 mg.

Dosage: One or two teaspoonfuls of the Elixir or one or two Tablets four times a day—one-half hour before meals and before bedtime.

Available: Elixir: Pint and Gallon bottles. Tablets: Bottles of 100 and 1000.

References: 1. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics, 2nd Ed., New York, Macmillan Company, 1955. 2. O'Reilly, P. O., Demay, M. and Kotlowski, K.: Cholesteremia and Nicotinic Acid. A.M.A. Arch. Int. Med. 100:797-801 (Nov.) 1957.

STORCK Pharmaceuticals, Inc.,
2326 Hampton Blvd., St. Louis 10, Mo.



"Sometimes, when I have a running nose, I'd like to clear it with TRIAMINIC®— just to check out that systemic absorption business.

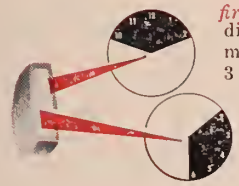
Reaches all nasal and paranasal membranes, huh?"

...and for humans with RUNNING NOSES...

You can't reach the entire nasal and paranasal mucosa by putting medication in a man's nostrils — any more than you could by trying to pour it down an elephant's trunk. TRIAMINIC, by contrast, reaches *all* respiratory membranes *systemically* to provide more effective, longer-lasting relief. And TRIAMINIC avoids topical medication hazards such as ciliary inhibition, rebound congestion, and "nose drop addiction."

Indications: nasal and paranasal congestion, sinusitis, postnasal drip, upper respiratory allergy.

Relief is prompt and prolonged because of this special timed-release action:



first— the outer layer dissolves within minutes to produce 3 to 4 hours of relief

then— the core disintegrates to give 3 to 4 *more* hours of relief

Each Triaminic timed-release Tablet provides:

Phenylpropanolamine HCl	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

Dosage: 1 tablet in the morning, midafternoon and at bedtime. In postnasal drip, 1 tablet at bedtime is usually sufficient.

Each timed-release Triaminic Juvelet® provides:
½ the formulation of the Triaminic Tablet.
Dosage: 1 Juvelet in the morning, midafternoon and at bedtime.

Each tsp. (5 ml.) of Triaminic Syrup provides:
¼ the formulation of the Triaminic Tablet.
Dosage (to be administered every 3 or 4 hours):
Adults—1 or 2 tsp.; *Children 6 to 12*—1 tsp.;
Children 1 to 6 — ½ tsp.; *Children under 1* — ¼ tsp.

TRIAMINIC® *timed-release tablets, juvelets, and syrup*

STOP *running noses* *and open stuffed noses orally*

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska

for relief of hypertension

RUHEXATAL WITH RESERPINE

for

Rapid and Prolonged

BLOOD PRESSURE REDUCTION

RELIEF OF ANXIETY AND TENSION

Protection Against

CAPILLARY FRAGILITY

A therapeutic combination providing a safe, effective, long range treatment of hypertension with minimal side effects high patient acceptance and economy.

Each tablet contains Reserpine 0.1 mg. Mannitol Hexanitrate 30 mg. Rutin 20 mg. Ascorbic Acid 10 mg.

LEMMON PHARMACAL CO. SELLERSVILLE, PA.

preventable tragedy:
permanent pitting and scarring in acne

in acne vulgaris:
for effective control of the pyogenic organisms
often responsible for permanent pitted and hypertrophic scars[1]

Tetrex® capsules
U. S. PAT. NO. 2,791,609
The Original Tetracycline Phosphate Complex

broad spectrum efficacy with unmatched record of safety and tolerance

Supply: TETREX Capsules—tetracycline phosphate complex—each equivalent to 250 mg. tetracycline HCl activity. Bottles of 16 and 100. Capsules—100 mg.—bottles of 25 and 100. Information on convenient dosage schedule available on request.

1. Rein, C. R., and Fleischmajer, R.: The efficacy of tetracycline phosphate complex (TETREX) in dermatological therapy. Antibiotic Med. & Clin. Ther. 4:422 (July) 1957.

BRISTOL™
BRISTOL LABORATORIES
SYRACUSE, NEW YORK

for maximum effectiveness Recently, Griffith[1] reported that V-Cillin K produces antibacterial activity in the serum against penicillin-sensitive pathogens which is unsurpassed by any other form of oral penicillin. This helps explain why physicians have consistently found that V-Cillin K gives a dependable clinical response.

for unmatched speed Peak levels of antibacterial activity are attained within fifteen to thirty minutes—faster than with any other oral penicillin.[1]

for unsurpassed safety The excellent safety record of V-Cillin K is well established. There is no evidence available to show that any form of penicillin is less allergenic or less toxic than V-Cillin K.

Prescribe V-Cillin K in scored tablets of 125 and 250 mg., or V-Cillin K, Pediatric, in 40 and 80-cc. bottles.

1. Griffith, R. S.: Comparison of Antibiotic Activity in Sera Following the Administration of Three Different Penicillins, Antibiotic Med. & Clin. Therapy, 7:No. 2 (February), 1960.

V-CILLIN K® (penicillin V potassium, Lilly)

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U.S.A.

033001

THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • o

Responsible Means Answerable

Responsible means answerable. Doctors are among the most "responsible" people on earth. They are "answerable" for lives, limbs and health to a degree not approached by anyone else. Responsible means not only "answerable," but also "answering": that is knowing (or knowing where to find) and giving the "answers." The general practitioner takes responsibility for the total health care of an individual. Whether the patient wants to know about diet, exercise, sleep, medication or smoking, the family doctor is expected to give him the answers. This is also true of "generalists" in other fields. A general engineer or general contractor or "general" lawyer will take overall responsibility for putting up the entire structure or handling all of the client's legal affairs.

This is one aspect of specialization that is little discussed: its effect on responsibility. You cannot ask a specialist to take responsibility for the total patient. Indeed this is only one of several factors that are reducing the physician's responsibility. Individual responsibility is also lessened in group practice or, for that matter, in any kind of team-work. While team-work is wonderful, it must be confessed that it blurs the individual practitioner's responsibility. The increasing trend towards in-hospital practice, for instance, also provides a way in which the practitioner can divide (or sometimes avoid) responsibility. Other responsibility-lessening factors are the wider use of consultants and increasing dependence on the laboratory.

In the not so distant past, the M.D.'s unique position rested on his unique responsibilities. No matter what happened to the health of his patient, the attending general practitioner was responsible. Now, however, you can almost hear the proctologist say: "Yes—that le-

PUBLISHED MONTHLY SINCE 1904
Under the direction of the Committee on Publication
FRED B. ROGERS, M.D., *Chairman*

HENRY A. DAVIDSON, M.D., *Editor*
MIRIAM N. ARMSTRONG, *Assistant Editor*

Place of Publication, Printing and Mailing—116 Lincoln Avenue, Orange, N. J.
Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.
Send all communications for publication to P.O. Box 904, Trenton 5, N. J. — Telephone EXport 4-3154
Each paying member of the State Society is entitled to receive a copy of THE JOURNAL every month
Whole Number of Issues 673

VOL. 57, NO. 9 SEPTEMBER, 1960 Subscriptions, $3.00 per Year Single Copies, 30 Cents

sion was in the ascending colon—not in my area, of course—but proctologically speaking (or maybe proctology-wise) he is in good shape." The ophthalmologist will recognize a diabetic cataract, but he will not be "responsible" for a treatment regime for the diabetes. (Ophthalmologically, he will say, the patient is doing all right now). And you can always let the pathologist, the consultant or the x-ray laboratory take responsibility for a judgment.

The factors which chip away at responsibility are all "modern": hospital practice, group practice, team-work, consultant services, specialization, and extensive laboratory studies. Important as all these advances certainly are, they do tend to weaken the doctor's sense of responsibility. Residency training, university affiliation and military experience—all part of the modern practitioner's development—impress on the young doctor the importance of sharing responsibility, of looking to a big brother for an answer. A young physician may come out of a residency superbly trained—yet without ever in his whole career, having made a medical decision without a superior to advise him.

These melancholy reflections are not aimed at turning the clock back. But perhaps it would be well if, in training younger doctors we developed some way of giving them the smell of responsibility—of total answerability. That, or face the fact that we cannot unload our responsibilities without affecting our public image.

Fraternal Orders and Medical Care

One of the quieter components of good medical care is the extensive, but often unsung contributions of the fraternal orders in this country. Shriners, for example, pour 20 million dollars a year into hospitals, blindness study, mental hygiene and medical research. The Odd Fellows operate more than 60 institutions for the care of children and old people. Among Odd Fellow projects are the World Eye Bank and the Visual Research Foundation. Elks spend millions in cancer research and in the support of convalescent homes. Child City in Illinois is a project of the Loyal Order of Moose. And in Florida, this lodge operates a model community for the aged—City of Contentment. A blood transfusion program has long been a Knights of Columbus project. The Eagles have been in the forefront of the fight against tuberculosis. B'Nai Brith has a well known disaster relief program. Kiwanis Clubs are identified with an automobile accident prevention project. The Lions have been vigorous in sight-saving work, and camps for crippled children. Mention must also be made of the many magnificent health-interest projects sponsored by veterans' organizations, their auxiliaries and women's clubs.

The list could be extended indefinitely, but space does not permit a listing of all the lodges and civic organizations that toil in the health field. Nor is it necessary to list them all, since a characteristic of these programs has been their modesty in not panting for "credit." These organizations are sometimes ridiculed by sophisticates, but the fact is they represent an enormous human resource which operates without selfish motivation or self-aggrandizement. They are typically American—not only in their historical development, but also in their devotion to the principle of neighbor help neighbor.

Original Articles • • •

JOSEPH G. STELLA, M.D.

Atlantic City

Advances in Office Diagnosis in Gynecology*

In addition to the standard history-taking and clinical examination, the gynecologist has such diagnostic aids as colposcopy, cytology, and mucus study. Dr. Stella reviews the values and limitations of each.

TRADITIONALLY, the gynecologist depends upon history, the speculum, and bimanual pelvic examination to arrive at a diagnosis. While these technics are most important, it is the purpose of this paper to discuss aids to gynecologic diagnosis which, in recent years, have been established as procedures readily performed in the office.

CYTOLOGY

CYTOLOGY has made a significant contribution in the diagnosis of gynecologic conditions. The study of desquamated epithelial cells (developed by Papanicolaou) is associated with cancer detection. It is of vast importance. Screening of vaginal or uterine smears for cancer cells is hardly an office procedure, unless the practitioner is adequately trained. However, vaginal cytology imparts information other than the presence of malignant cells which can be readily ascertained without prolonged training and experience.

The functional status of the ovary is reflected by characteristic changes in the vaginal epithelium. Epithelial cells may be obtained from the posterior vaginal fornix with a glass pipette, placed on a slide, and stained by the Shorr stain, which is commercially available, or by the use of a method developed by Rakoff.[1] In his technic, epithelial cells are obtained by scraping the lateral vaginal wall in its midportion with cotton tipped applicators. The applicators are then dropped into a test tube containing 2.5 cubic centimeters of normal saline, and three drops of the following staining solution are added:

10 per cent aqueous solution of Light Green —83 c.c.
1 per cent aqueous solution of Eosin Y —17 c.c.

The basophilic precornified cells stain green and the acidophilic cornified cells stain pink. This method is accomplished rapidly, and the wet preparation may be dropped on a glass slide and observed under low power magnification of the microscope.

In the normal reproductive cycle, the early follicular phase is characterized by the finding of precornified superficial cells whose nuclei are round, active, and whose cytoplasm stains blue or basophilic. As the ripening follicle pro-

*Read May 17, 1960 before the Gynecologic Section of the Annual Meeting of The Medical Society of New Jersey.

1. Rakoff, A. E.: Progress in Gynecology. Grune and Stratton, vol. 2 (1950).

duces more estrogen, the superficial cells become more mature, and the smear contains an increasing number of cornified acidophilic staining cells with small pyknotic nuclei. During the ovulatory phase, estrogen production is at its peak and the smear then contains a predominance of the acidophilic, cornified superficial cells. The post-ovulatory or corpus luteum phase of the menstrual cycle is reflected in the vaginal smear by the regression of the large numbers of cornified acidophilic cells with curling of the edges and crowding together of those precornified superficial cells present. As the progestational effect becomes more pronounced, the predominance of basophilic staining cells clumped together is more obvious, and finally in the premenstrual phase of the cycle, the cells begin to lose their staining reaction, undergo cytolysis, and large numbers of leukocytes are present as well as cellular debris.

In ovarian deficiency, a third type of cell is noted in the vaginal smear. These are called parabasal cells since they are derived from the deeper layers of the vaginal epithelium. Parabasal cells are small, round, or slightly ovoid. Their cytoplasm takes a basophilic stain, and the nuclei are relatively large and round. The count of parabasal cells denotes the degree of estrogen deficiency. In many females approaching genital senility, the vaginal smear contains only parabasal cells along with numerous leukocytes. These smears are classified as denoting marked estrogen deficiency. Where a moderate estrogen deficiency exists (as in the majority of postmenopausal patients or young women with long standing ovarian deficiencies) the majority of cells are from the basal layer; but there are also some from the intermediate and superficial layers of the vaginal epithelium. During normal pregnancy, there is a marked increase in both estrogen and progesterone which is manifest in the vaginal smears by the occurrence of clumps of basophilic, precornified cells, some of which assume an elongated or navicular shape. The latter cells are referred to as pregnancy cells and may be readily identified, but are not specific.

In the study of the infertile female patient, it is of paramount importance to determine whether ovulation is occurring during the menstrual cycle. This may be ascertained cytologically by first examining a smear made during the postmenstrual phase at the same time the Rubin test is being done. A second smear is examined at approximately midcycle in conjunction with the Sims-Huhner test, and a third smear at approximately day 22 of the menstrual cycle. If progression of estrogen effect is noted between the first two smears, and if progestational effect is present in the last smear, then one may conclude that the patient probably ovulated during that particular cycle. However, in the absence of obvious normal cyclic change, then the smears should be repeated during several more cycles and the information correlated with basal temperature charts and an endometrial biopsy, which may also be performed innocuously in the office. No claim is made that the exact day of ovulation can be determined by the use of cytology.

In the study of the amenorrheic patient, cytology is useful in that an estrogen deficiency type of smear denotes either primary ovarian failure or inadequate stimulation of the ovaries by the pituitary gland. The amenorrheic patient whose vaginal smear shows a good estrogen effect must be suspected of having an endometrium which is not responding to estrogenic stimulation. Diagnostic emphasis would then be placed on disclosing the underlying endometrial pathology.

The 40-year old who presents with a history of amenorrhea and in whom is found an enlarged uterus, may be diagnosed in the office with the aid of vaginal cytology. A slightly deficient smear or one showing good estrogen effect would suggest a fibroid uterus rather than pregnancy.

Adolescent females who suffer dysfunctional uterine bleeding are frequently a problem because these individuals may be bleeding from either a hypoestrogenic or hyperestro-

genic endometrium. In these cases, vaginal cytology aids in deciding whether the treatment of choice shall be estrogen or progesterone.

Threatened abortions on the basis of poor corpus luteal function or placental insufficiency may frequently be diagnosed employing the vaginal smear. Smears made from these disturbed pregnancies will reveal the presence of eosinophilic cells signifying that there has been an estrogenic breakthrough, frequently before the onset of bleeding.

While the study of genital smears for cancer cells is not an office procedure, the proper preparation of these smears for study definitely is. Prior to taking smears, the patient must not have douched for at least 24 hours. Smears made from the vaginal pool and from cervical scrapings will suffice in detecting the majority of cervical lesions. However, many carcinomas of the endometrium will be undetected if only these smears are taken. Practitioners should, therefore, equip themselves with intrauterine cannulae and train themselves to introduce the cannula gently and sample the endometrial cavity. By taking an endometrial aspiration, the positive diagnosis of endometrial carcinoma in most cytology laboratories has increased from 50 per cent to 85 per cent. Perforation of the uterus and introduction of infection need not accompany this procedure if done gently and under reasonably aseptic conditions.

CERVICAL MUCUS

In recent years, increasing attention has been focused on the study of the cervical mucus. Cyclic changes in the character and quantitative secretion of the cervical mucus have been observed corresponding to increasing estrogen production and the inhibiting effect of progesterone. The recent prominence of the study of the cervical mucus as an aid in diagnosis has stemmed largely from the fact that a phenomenon observed first by Papanicolaou has also been correlated with ovarian activity. This phenomenon is referred to as cervical mucus arborization, ferning, or palm leaf reaction. During the normal menstrual cycle, the cervical mucus undergoes characteristic changes. In the immediate postmenstrual phase, the mucus is scant, thick, tenacious, and contains many epithelial cells and leukocytes. As follicular activity increases, the mucus becomes more abundant, watery in consistency, elastic and acellular.[2] The mucus in this phase of the cycle if left to dry on a glass slide will present a typical fern or palm leaf pattern, which can be readily recognized under low power magnification of the microscope. The elasticity and fern phenomenon reach a peak at the ovulatory phase and are maintained until approximately day 22 of the cycle when they then revert to postmenstrual characteristics, and the mucus loses its ability to arborize. For years, gynecologists have studied the elasticity of mucus called *spinnbarkeit*, as an index to the time of ovulation, and there are those[3] who maintain that the day of ovulation can be pinpointed by studying *spinnbarkeit*.[4] Since *spinnbarkeit* does occur in the majority of women who ovulate, the simple testing of the elasticity of the cervical mucus is certainly helpful in the investigation of an infertile female.

Zondek, Forman and Cooper[5-9] have worked on the clinical application of cervical mucus arborization. As in the case of vaginal cytology, study of the cervical mucus in the postmenstrual, midcycle, and 22nd day of the cycle is most useful in determining whether ovulation has occurred and is also indicative of corpus luteum function. It is also helpful in the study of the amenorrheic patient in that cervical mucus will fail to show a fern reaction in marked ovarian failure, but will

---

2. Roland, M.: Amer. Journ. Obstetrics & Gynecology, 63:81 (1952).
3. Speck, G. and Halter, P.: Fertility & Sterility, 7:341 (1956).
4. Cohen, M. R. *et al.*: Fertility & Sterility, 3:201 (1952).
5. Forman, I.: Obstetrics & Gynecology, 8:287 (1956).
6. Zondek, B.: International Journal of Fertility, 1:225 (1956).
7. Zondek, B. and Cooper, L.: Obstetrics & Gynecology, 4:484 (1954).
8. Zondek, B. *et al.*: Fertility & Sterility, 6:523 (1955).
9. Zondek, B. and Rozin, S.: Obstetrics & Gynecology, 3:463 (1954).

undergo the characteristic cyclic changes if the endometrium is refractory. In pregnancy, past the third or fourth week, the cervical mucus fails to undergo arborization, and it cannot be brought about by the injection of estrogen. The differentiation between pregnancy and a soft myoma is made possible in the presence of a good fern reaction. As a test for pregnancy, however, it would seem that it would not equal the efficiency and accuracy of those tests based upon chorionic determinations. The application of cervical mucus arborization in the detection of placental insufficiency, however, does have merit providing the patient is not bleeding, since blood will inhibit "ferning." Studies at Temple University demonstrated a significant incidence of pregnancy loss where arborization persisted in early pregnancy.

Cervical mucus is obtained by exposing the cervix, swabbing it clean, and the mucus taken from the endocervix with a vaginal pipette or cotton tipped applicator. A small amount is placed on a glass slide and covered with a cover glass. The cover glass is then gently lifted, stretching the mucus. About the time of ovulation, *spinnbarkeit* measures 10 or 15 centimeters. Another portion of the mucus is spread evenly over another glass slide, observed microscopically for leukocytes, spermatozoa and epithelial cells. It is then allowed to dry and observed for arborization.

COLPOSCOPY

While genital cytology has been universally accepted as an excellent aid in the early diagnosis of pelvic malignancy, there is another method which has been slowly accepted in this country. Colposcopy is a technic by which the cervix is inspected under magnification. It was first described by Hinselmann in 1925. The method is widely used in Europe, particularly in Germany and Austria, and has been recently popularized in this country by the work of Scheffey [10] and Lang [11] at the Jefferson Hospital Clinic. By means of the colposcope, suspicious cervical epithelia, not identifiable with the naked eye, may be detected. Additionally, vulvar and vaginal lesions may be studied. Unlike cytology, lesions high in the endocervical canal and endometrial lesions cannot be detected using the colposcope.

With a moderate amount of training, the clinician can easily recognize normal findings such as transformation zone, ectropia and inflammatory changes. Atypical epithelium such as simple leukoplakia, ground leukoplakia, and mosaic leukoplakia, the latter two types visible only colposcopically, are also readily identified. Irregularity of the blood vessels, so-called adaptive hypertrophy, is another colposcopic finding suggestive of malignancy. Colposcopy is an office procedure. It pinpoints suspicious areas for biopsy, and if used in conjunction with cytology, the proportion of positive diagnosis of subclinical cervical lesions is increased. Navratil [12] states that with cytology alone, 79 per cent of cervical malignancies were diagnosed: 74 per cent with the colposcope; but, using both methods, 96 per cent were recognized.

SUMMARY

A brief review of vaginal cytology, cervical mucus study and colposcopy have been presented. All these methods represent advances in office diagnosis if properly applied and if their limitations are understood.

18 South Stenton Place

10. Scheffey, L. C. *et al.*: Obstetrics and Gynecology, 5:3 (1955).

11. Lang, W. R.: Proceedings of the Third National Cancer Conference, Kenosha, Wisconsin (1952).

12. Navratil, E.: Progress in Gynecology. Grune and Stratton, vol. 3 (1957).

William J. Dougherty, M.D., M.P.H.
David P. Hammond
Trenton

Cluster Testing

A New Dimension in Syphilis Epidemiology

A new technic of contact investigation and case interviewing is here introduced to our readers. Dr. Dougherty is director of the Division of Preventable Diseases in our State Health Department. Mr. Hammond is a Health Program Representative of the U.S.P.H.S.

The attack rates of early infectious syphilis in New Jersey since 1955 indicate that the incidence of early syphilis is increasing and that the former downward trend has been reversed. This reversal of trend dictates a need for increased vigor in control activity. Reports for 1959 show that there were 302 cases of infectious syphilis newly discovered in the state. Forty-two per cent were among persons from 15 to 24 years of age. This concentration of infectious syphilis in a young, sexually active age group calls for a maximum epidemiologic effort.

The basic epidemiologic principle of progression from a reported case of infectious syphilis to the discovery of additional cases among sexual contacts is the core of venereal disease control. Contact investigation has been recognized for many years as a valid and useful component of syphilis control programs. This technic requires conscientious, effective interviewing of an infectious or recently infected patient for sex contact information and diligent investigation of the contacts named.

Although contact investigation has contributed immeasurably to prevention and control of syphilis, it has obvious limitations. Even the most expert interviewers frequently fail to completely overcome a patient's reticence to reveal all contacts; they elicit some names, but not all. The most cooperative patient may forget some of his contacts or may not know some of them well enough to name them, or even to describe them adequately. Some contacts cannot be located due to inadequate information or due to the fact that they may move about from place to place.

A recently systematized method of broadening the base of syphilis epidemiologic investigation, *cluster testing,** has become widely accepted since its introduction.[1]

Cluster testing is based on two premises: first, that the chain-of-infection investigation of sexual partners is not likely to uncover separate but socially related chains of infection within the same sexual community; second, that syphilis patients are likely to know potential syphilis patients in their community even though they may have no sexual linkage with them.[2] A successful cluster testing opera-

*You may obtain a film explaining this technic by requesting it from the VD Control Officer, State Department of Health, Trenton 25, N. J. This is an interesting and valuable training film, appropriate for medical societies and hospital staff meetings.

1. Swank, R. R.: Preliminary Report on Cluster Testing in Georgia. Report presented at Venereal Disease Control Seminar in Detroit, Michigan, March 1957.

2. Richman, T. LeFoy: Venereal Disease, Old Plague—New Challenge. Public Affairs Pamphlet No. 292. Public Affairs Committee, Inc., Jan. 1960.

tion will reveal some cases of syphilis linked in a chain of infection, and, in addition, others interrelated through the patients' similarity of sexual experience and exposure to a common sexual environment.

The first step in cluster testing is to interview a patient for his sexual contacts. At the conclusion of an interview, the patient is questioned concerning individuals referred to as cluster suspects. This category includes:

1. Acquaintances who, the patient believes, might benefit from a blood test.
2. Persons believed to have lesions similar to those of the patient.
3. Persons thought to have been exposed to contacts of the patient.
4. Other promiscuous persons.

Another category, *cluster associates,* is comprised of persons identified in any of the following ways:

1. Found or observed in the company of the patient, contacts or suspects.
2. Named as sexual partners of contacts.
3. Named by contacts or suspects as members of the same social circle or group.
4. Observed in social resorts frequented by the patient and his contacts.
5. Co-workers of patient or contacts.
6. Occupants of residences of patient or contacts.

The foregoing are not inflexible criteria for selection of persons to be included in a cluster. They are generally accepted guides, but in the evolution of a specific cluster, they are applied with discretion and in accordance with sound public health practice. Large numbers of people may be included in a cluster, but selectivity is required in order to avoid exceeding the point of diminishing returns.

In operation, the venereal disease epidemiologist first locates sexual contacts and assures that they report for medical examination. He then locates cluster suspects, offering to them free on-the-spot collection of blood for a serologic test for syphilis. In the course of these activities he is constantly alert to discover cluster associates and provides to them the same opportunity for a serologic test. Submission to cluster testing is voluntary. The offer of a blood test usually is preceded by a frank presentation of pertinent venereal disease information indicating to the suspect or associate that he is in an environment in which the risk of syphilis is high.

Venereal disease epidemiologists assigned to perform cluster testing are trained and skilled in technics of interviewing and venipuncture and are equipped with field kits for the collection of blood samples. They are impressed with the necessity for maintaining professional confidences and exercise utmost care in protecting the employment, social, and marital status of persons receiving epidemiologic services.

Cluster testing is not conducted on a community-wide base, and mass-appeal media are not employed to promote it. The effectiveness of the procedure depends upon case-oriented selectivity and the persuasive technic of the individual epidemiologist.

Since 1956, some cluster testing has been done in 31 states and 51 major cities in the United States.[3] The effectiveness of this procedure in Georgia is indicated in Table 1. Nineteen hundred and thirteen primary and secondary syphilis patients led to epidemiologic investigation of 44,172 persons. The examination of sex contacts resulted in discovery of 834 new infectious cases. Cluster testing around the 1913 cases added 347 more primary or secondary cases to the yield.

Further, the cluster technic resulted in earlier discovery, earlier therapy and reduced the potential of the 347 cases to perpetuate the chain of infection. The latent cases found constituted a valuable addition to the syphilis control effort.

Similarly productive activity in New York City is illustrated in Table 2 and Figure 1. The most striking feature of this cluster testing is that 7 of the 25 associates tested were brought to treatment for infectious syphilis.

After analysis of reports of cluster testing from numerous states and cities, Richman[2] stated that "the results thus far have been more than hoped for," and that cluster testing has substantially increased epidemiologic yield. Clark,[4] among other leading venereal

3. Today's VD Control Problem. Joint Statement of The Association of State Health Officers, the American Venereal Disease Association, and The American Social Health Association, February 1960.

4. Clark, E. G.: Journal-Lancet, 80:1 (January 1960).

TABLE 1.

REPORT OF CLUSTER TESTING ACTIVITY†

State of Georgia: July 1, 1956—March 18, 1960

Source Patients: 1913 Primary and Secondary Syphilis Patients

Number	Contacts	Suspects	Associates	Total
Obtained	9885	10099	24188	44172
Located and Examined	8968	9785	23921	42674
Reactive	3025	1187	2073	6285
Infected	2963	1051	1721	5735
Brought-to-Treatment:				
Pri. & Sec. Syphilis	834	159	188	1181
Early Latent Syphilis	213	47	108	368
Late Latent Syphilis	23	40	132	195
Other Syphilis	12	11	29	52
Returned to Treatment	155	136	453	744
Under Rx now or has received Rx within 12 mos.*	1726	658	811	3195
Not infected with Syphilis	6005	8734	22200	36939
Not Examined	917	314	267	1498

*No additional treatment recommended (Pos. serology or spinal with treatment over 1 year ago) appear on "Reactive" and "Not Infected with Syphilis" lines.

†Table provided through courtesy of R. R. Swank, Health Program Representative, Division of Venereal Disease Control, Georgia Department of Health.

disease control authorities, has described cluster testing as "very productive" and has promoted more extensive application of the technic.

Successful handling of the current resurgence of syphilis in New Jersey, to which the attention of the medical and public health professions has been directed recently,[5] demands utilization of all available resources. It is particularly urgent in New Jersey, in view of alarming increases in infectious syphilis, that there be full realization of the potential of cluster testing as a syphilis case-finding adjunct and control measure.

Prompt incorporation of cluster testing in the case-finding activity of every public health agency in New Jersey and the assistance of all physicians and public health agencies in carrying it forward are urgently indicated.

TABLE 2.

REPORT OF CLUSTER TESTING ACTIVITY EMANATING FROM 47 CASES OF PRIMARY AND SECONDARY SYPHILIS‡

New York, N. Y.: July 1, 1958—March 31, 1959

Source Patients: 47 Primary and Secondary Syphilis Patients

Number	Contacts	Suspects	Associates	Total
Obtained	162	73	34	269
Located and Examined	125	54	25	204
Reactive STS	43	8	10	61
Infected	43	8	10	61
Brought to Treatment:	17	5	8	30
Pri. & Sec. Syphilis	14	3	7	24
Early Latent Syphilis	3	2	1	6
Other Syphilis	0	0	0	0
Returned to Treatment	7	1	0	8
Adequately treated Previously	19	2	2	23
Not infected	82	46	15	143
Not examined	37	19	9	65

Note: Eighty-five contacts, suspects and associates who were not infected were given epidemiologic treatment.

‡Table provided through courtesy of Jules E. Vandow, M.D., Chief, Division of Social Hygiene, New York City Department of Health.

Fig. I

RESULTS OF CLUSTER TESTING EMANATING FROM 47 CASES OF PRIMARY AND SECONDARY SYPHILIS

NEW YORK CITY JULY 1, 1958 TO MARCH 31, 1959

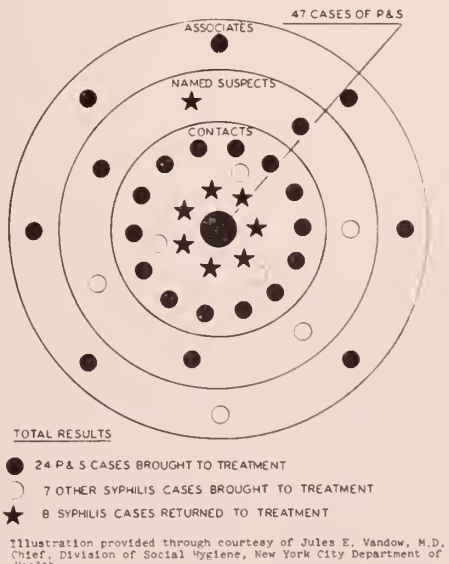


Illustration provided through courtesy of Jules E. Vandow, M.D. Chief, Division of Social Hygiene, New York City Department of Health

5. Dougherty, W. J. and Hammond, D. P.: The Journal of the Medical Society of New Jersey, 57:237 (May 1960).

SUMMARY

CLUSTER TESTING is a logical extension of case interviewing and contact investigation practices which are well established as essential in the control of infectious syphilis. Cluster testing is a specific epidemiologic activity that provides for serologic examination of a wide range of persons within the sex community of which the infected patient is a member. It affords the opportunity to broaden selectively the scope of epidemiologic investigation and to bring the benefit of serologic examination to persons other than sex contacts. It vastly improves the chances that unrevealed contacts will be blood tested. Seroreactors in the social cluster which has as its nucleus an infectious syphilis patient are referred for further examination, diagnosis and treatment.

Cluster testing aids in discovery of chains of infection apparently only remotely related, if at all, to the original case interviewed. Full exploitation of cluster testing is needed to meet the challenge of the current syphilis resurgence in New Jersey.

State Department of Health

The Vanishing GP

How far has the surgeon replaced the general practitioner in the operating room? According to *Patterns of Disease,* a Parke, Davis and Company publication, the role of general practitioners in surgery is still an important one. Almost half of all general practitioners in the United States do minor surgery.

However, the trend points increasingly to specialized training. Between 1950 and 1958, *Patterns* reports, the total number of physicians in this country increased by 9 per cent; surgeons by 26 per cent, and anesthesiologists by 126 per cent. The number of general practitioners decreased by 6 per cent during this same period.

N. J. Diplomates in Obstetrics and Gynecology

In the August 1960 issue of this JOURNAL (page 498) we published a list of recently certified diplomates in gynecology. We are now advised that all these doctors were certified in both obstetrics and gynecology on April 15, 1960, and the list is here reproduced in fairness to the physicians mentioned. THE JOURNAL apologizes for the error.

Anthony P. Caggiano, Upper Montclair
C. Gregory Caltabiano, Dumont
Adolph B. Clachko, Hackensack
Albert M. Doswald, Bound Brook
Ernest P. Geenberg, Union
Severin T. Golojuch, New Brunswick
William M. Griffin, Hackensack
William H. Hayling, Newark
Earl I. Kanter, Margate
Herbert Langer, Cranford
Frank F. Liegner, Newton
George M. Massell, Red Bank
John C. Mutch, Moorestown
Frederick L. Perl, Bound Brook
Charles A. Rentrop, Jr., Ridgewood
Arthur J. Ruccia, Newark
Paul E. Stroup, Collingswood

Walter A. Petryshyn, M.D.

Flemington

Infectious Versus Allergic Rhinitis and Sinusitis*

Newer knowledge of nasal physiology, as Dr. Petryshyn here points out, has led to newer and more effective methods of treating allergic rhinitis and distinguishing it from infectious rhinitis.

The present concept of nasal and sinus disease is dependent upon our knowledge of the anatomy, physiology, and pathology of these organs. When the deviation from the normal is recognized and understood, rational therapy can be given.

The nasal chamber is a rigid space with an anterior and posterior opening; the nares and the posterior choanae. Within this rigid space are the nasal turbinates which expand and contract in size depending upon the physiologic and environmental circumstances. Except for the anterior portion of the nasal septum, the anterior tip of the inferior turbinate and the olfactory area; the entire nasal cavity is lined with pseudo-stratified, ciliated, columnar, respiratory epithelium. Many of our essential nasal functions are carried on by two structures; the respiratory epithelium and the nasal turbinates.

The respiratory epithelium contains goblet cells which secrete mucus. Additional seromucinous glands lie in the connective tissue beneath the epithelium. The mucus secreted by these glands lies as a covering blanket on the surface of the cilia. The motion of the cilia is such that this mucus blanket is swept posteriorly into the pharynx and usually swallowed. Where the mucus becomes excessive in quantity or irritating to the membranes of the throat, we recognize it as a post-nasal drip. Mucus has other valuable functions. It attracts and holds dust particles and bacteria, acting as an efficient air filter. By being bacteriostatic, bacterial proliferation is controlled. The mucus protects the epithelium from drying out. By supplying moisture to the dry air it acts as a humidifier. The cilia are so aligned that the flow of the mucus is towards the natural ostia of the sinuses. This nasal membrane is a remarkable organ. It filters, sterilizes and humidifies the air, while keeping itself clean.

The nasal turbinates are essential in the temperature control of the inspired air. The numerous large blood vessels which lie under the mucous membrane are surrounded with smooth muscle which contracts and dilates under the influence of the autonomic nervous system, controlling the size of the nasal turbinates. When these blood vessels are dilated, the nasal airway is narrowed and the turbinates present a greater surface area to warm the air. When the blood vessels contract, the turbinates shrink and the nasal airway is increased.

The ostia of the nasal sinuses open under-

*Read May 18, 1960 before the Allergy Section, The Medical Society of New Jersey, Annual Meeting in Atlantic City.

neath the turbinates. When the turbinates are in their normal state, the contents of the nasal sinuses can drain without obstruction. When the turbinates are swollen (or when polyps are present) drainage is interfered with and mucus stagnates in the sinus. This predisposes the sinus to secondary infection.

PATHOLOGY

When nasal disease is present, pathologic changes occur in the respiratory membrane and in the turbinates which produce symptoms. The acute phase of the *common cold* is characterized by hyper-secretion of mucus, edema and increased vascularity of the tissues. This is the tissue response to injury, which in this instance is due to a virus or viruses. Ordinarily this phase is self-limited. When secondary infection occurs with a virulent organism, complications are produced. In this secondary phase, the nasal secretion becomes purulent. When there is sufficient edema of the tissues (or if the nasal secretions are viscid) the sinus orifices become blocked, creating an enclosed space in which bacteria readily proliferate. This process may continue with disintegration of the nasal membrane and destruction of the adjacent bone.

In the allergic state, we have a somewhat similar inflammatory reaction. The acute phase is characterized by hypersecretion of mucus and edema of the tissues causing rhinorrhea and nasal obstruction. This process, if not controlled, will also become secondarily infected. In time, the edema of the nasal tissues will lead to polyp formation. Since the same membrane lines the sinuses, polyps will occur there also.

Histologically the nasal polyp presents an allergic inflammatory process. The epithelium is relatively unchanged, but the connective tissue stroma shows marked edema and infiltration with plasma cells and numerous eosinophiles. In a long standing process the eosinophiles are present in great numbers. These cells migrate through epithelium to the surface and are found in the nasal smear.

Papillary sinusitis is often confused with nasal polyposis but is found less frequently. Some authorities feel that it is a neoplastic process due to the metaplasia of the respiratory epithelium. Others believe that it is inflammatory because of the presence of inclusion bodies. Histologically, the epithelium shows metaplasia to stratified squamous and is hyperplastic. Grossly the lesion is deep red in color with a granulated surface. When this lesion is thoroughly exenterated with surgery, it usually does not recur.

Holmes [1] has shown the range of response of the normal nose to provoking situations. In some people, tension and anxiety produce nasal obstruction. Theoretically, this is due to the action of the autonomic nervous system upon the cavernous blood vessels in the turbinates. However, more study is needed to determine the exact physiologic response of this entity, which is called *vasomotor rhinitis.*

DIAGNOSIS

Acute infectious rhinitis starts with rhinorrhea, sneezing, nasal obstruction and a feeling of malaise. At this point the infectious rhinitis closely resembles acute allergic rhinitis, although the allergic state is usually characterized by more sneezing. Acute rhinitis will either subside within a few days, or the characteristics of the nasal discharge will change. When a nasal sinus is acutely inflamed, the patient has pain in the involved area and discomfort when the sinus is percussed. An acutely infected sinus usually produces fever and systemic toxicity. Acute allergic rhinitis seldom produces pain in the sinuses. When there is no infectious or allergic history and the patient complains of an acute onset of nasal obstruction, investigation of the patient's emotional background may reveal a vasomotor rhinitis based on anxiety or tension.

Chronic rhinitis and sinusitis are less well

1. Holmes, T. H., Goodell, H., Wolf, S. and Wolff, H. G.: The Nose—An Experimental Study of Reactions Within the Nose in Human Subjects During Varying Life Experiences. Charles C Thomas (1950).

defined. A thorough history is needed to elicit allergic factors. Chronic infectious rhinitis and sinusitis are usually a series of *acute* exacerbations of infection. The low grade inflammations which appear to be constant and perennial are frequently allergic.

The appearance of the nasal mucosa indicates whether an infectious or allergic reaction is occurring. The acute infection produces redness and swelling of the membrane and the allergic state is characterized by the pale, edematous tissues. Shrinking the nasal membrane with a vasoconstricting drug will permit a view of the meatuses and discovery of pus if any is present. The patient with a long allergic history frequently will reveal the pale glistening appearance of polyps in the meatuses.

A nasal smear is helpful in the differentiation of the two types of disease. The infectious case will show polymorphonuclear cells, lymphocytes or plasma cells while the allergic nose will have many more eosinophiles. Wright's stain (regularly used for blood smears) is satisfactory for staining nasal smears with a slight modification of technic. I prefer to fix the smear for two minutes and then stain with the buffer for an additional two minutes. This prevents the usual darkly stained, sometimes indistinguishable smear. In preparing the smear, spread the secretions out as thin as possible on the slide before it is stained.

TREATMENT

Our present therapy is based on the principle of restoring the normal physiologic state of the involved structures. The treatment of infectious nasal disease was radically altered by the new knowledge of nasal physiology. The acute process now is treated conservatively. The nasal membrane is decongested with a vasoconstricting drug such as 1 per cent ephedrine sulfate or 0.25 per cent phenyl ephrine hydrochloride (commercially available under the Winthrop-Stearns tradename of Neo-Synephrine®). If necessary, spot suction in the meatus is used to improve drainage from the sinuses. When pus is present, chemotherapy or antibiotics are given systemically. Their local use has only a transient effect because of the activity of the nasal cilia. The silver protein solutions such as Argyrol® have an irritative effect and should not be used and irrigation of the acutely inflamed sinus is contraindicated. The patient is made more comfortable by the local use of heat and analgesics. In the patient who has recurrent attacks of acute sinusitis, some mechanical factor may be present preventing the proper drainage from the nasal sinuses. In these cases, conservative nasal surgery such as a submucous nasal resection to correct a nasal septum deformity or out-fracturing of the turbinates may be helpful. The patient with a long standing sinus infection may require an antrotomy to treat the sinus adequately. This is particularly true in the antritis which is secondary to a dental infection.

Be cautious about the prolonged use of vasoconstricting nasal drops or sprays. Some patients develop a "rebound reaction" to these medications and find that they must use them constantly for relief of their nasal obstruction. When such a situation is suspected, the drops must be discontinued promptly and a systemic vasoconstrictor such as pseudo-epinephrine† is used for relief until the habit is broken.

Acute allergic rhinitis responds dramatically to the antihistamines. They relieve the symptoms promptly but do not cure the disease. The only therapy assured of any permanent success is desensitization or elimination therapy. If the allergy is seasonal, therapy should be planned so that sufficient levels of myosensitization are reached before the acute phase will begin. Although most allergic rhinitis is due to the inhalants, the ingested allergens must be eliminated since they can cause nasal symptoms. The old case of allergic rhinitis will be complicated with nasal polyps. These seldom disappear with desensitization treatment alone and require surgical removal. Their frequent recurrence indicates a lack of control over the allergic process. Polyps in the nasal sinuses

†Commercially available under the Burroughs-Wellcome tradename of Sudafed®.

obstruct the drainage and secondary purulent infection occurs. In these conditions they should be surgically removed from the sinuses. Patients whose allergic rhinitis is complicated by infection may also be helped by the administration of the antibiotics and autogenous vaccine.

Corticosteroids are seldom required in the handling of the allergic rhinitis or sinusitis. Although they produce almost magical results in shrinking nasal polyps and relieving nasal obstruction, this relief is temporary and occurs only while the patient is receiving the drugs. The pathology returns when they are discontinued. Sometimes they are necessary in the patient who cannot obtain relief in any other way for the nasal obstruction and in these cases, we prefer to use prednisone or prednisolone. Although these drugs lead to only minimal salt retention, they should not be used for prolonged periods. Hyposensitization is an efficient therapy in handling allergic rhinitis or sinusitis when properly administered.

The vasomotor rhinitis which is precipitated by anxiety or emotional tension is a chronic problem and requires insight into the patient's emotional background. Sometimes only reassurance is needed; but at other times, extensive psychotherapy. Tranquilizers may be of some benefit and referral for psychiatric care may also be needed.

Hunterdon Medical Center

Thyroid Cancer Study Project

The National Cancer Institute is studying carcinoma of the thyroid. If you have such a patient, it may be possible to effect his admission to the National Cancer Institute at Bethesda, Maryland. For details, write to Clinical Director, National Cancer Institute, Bethesda 14, Maryland. If the matter is urgent, telephone extension 3351 at Oliver 6-4000. This is a Washington, D. C. number.

Medical Review on Regular TV

A weekly review of medical news for physicians, using commercial television channels, is now available. The fifteen-minute program, "This Week in Medicine," is broadcast on Sunday afternoons.

Tests in four cities showed that even though "This Week in Medicine" could be seen by the public over regular channels, the technical language and subject matter limited the audience to physicians and members of allied health professions. Each program includes a summary of medical news and a filmed feature on some aspect of research, clinical medicine or surgery. It is the first use of regular television channels to reach a nationwide medical audience on a professional level.

The series is sponsored by Ciba and produced by the editorial staff and consultants of Medical News. News is gathered by the *Medical News* network of contributing editors and correspondents in this country and abroad. As in the biweekly newspaper, also sponsored by Ciba, the news and feature content are controlled by the editorial staff and medical consultants independently of the pharmaceutical company.

Information on prescription pharmaceutical products is given in scientific terms and is confined to pharmacologic properties. Clinical indications for use of drugs are *not* cited. Nonprescription drugs are never mentioned.

"A layman who happens to tune in will find the product information incomprehensible," according to T. F. Davies Haines, president of Ciba.

BEN SHEINER, M.D

Westwood

Postoperative Use of Trifluopromazine by the Drip Method*

A Preliminary Report

One of the unpleasant aspects of surgery has always been the battery of side-effects following general anesthesia. Dr. Sheiner here reports that trifluopromazine, by drip, has eliminated most of these undesirable effects and in most cases even induces a pleasant amnesia.

IN THIS study I used trifluopromazine hydrochloride† postoperatively in an attempt to eliminate the undesirable side effects of anesthesia and surgery. Trifluopromazine [1] is a phenothiazine similar to other phenothiazine derivatives.[2] It is a behavior-modifying drug [4] shown by animal and human studies [3] to have the ability of inhibiting both the sympathetic and parasympathetic nervous systems.[5] It depresses the carotid reflex in the sympathetic nervous system and it inhibits the bradycardic reflex response to epinephrine in the parasympathetic system.[5]

The phenothiazine derivatives have proved to be useful tools for the anesthesiologist. They are potent antiemetic agents which not only inhibit autonomic reflexes [1] but also potentiate narcotic and anesthetic agents.[2] They also sedate and tranquilize the patient.

For this preliminary study I used 100 patients. Forty-five received premedication consisting of promethazine along with a narcotic and belladonna derivative; and fifty-five received the narcotic and belladonna derivative alone. Postoperatively all were given an intravenous drip of one liter of 5 per cent glucose in water to which had been added twenty milligrams of trifluopromazine.† The drip was run at a rate of 40 to 60 drops per minute. Ages of the patients ranged from 15 to 72 years. The operations encompassed a wide field including head and neck, orthopedic, peripheral vascular, abdominal, genito-urinary and rectal surgery.

I used general anesthesia for all these patients. Induction was with thiopental sodium (using the Abbott brand, tradenamed Pentothal® Sodium) in average dose of 150 milligrams intravenously. Six patients were on

*Read at Atlantic City before the Section on Anesthesiology of The Medical Society of New Jersey, 194th Annual Meeting, May 18, 1960.

†Tradenamed by Squibb as Vesprin®.

1. Adelman, M. H., Jacobson E., Lief, P. A.: Journal of the American Medical Association, 169:5 (Jan. 3) 1959.

2. Dougray, T.: British Medical Journal, 2:1081 (Nov. 12) 1949.

3. Winter, C. A.: Journal of Pharmacol. & Exper. Therap., 94:7 (Sept.) 1948.

4. Gallagher, W. J. and Pfiefer, C. C.: Monographs on Therapy, The Squibb Institute for Medical Research, 2:188 (Aug.) 1957.

5. Piala, J. J., Hassert, G. L., High, J. P. and Burke, J. D.: Monographs on Therapy, The Squibb Institute for Medical Research, 2:214 (Aug.) 1957.

ether alone; ten were carried on a combination of nitrous oxide and ether; twenty-one were on cyclopropane and the remainder were carried on a combination of ether and cyclopropane. I used muscle relaxants when indicated. Postoperatively the patients were observed in the recovery room and in their beds. These 100 patients were then compared with a control series.

OBSERVATIONS

After the trifluopromazine drip was started, the patients remained in light slumber after the effects of the anesthetic agents had worn off. They could be easily aroused from this state of sleep. They would respond to questions, giving coherent answers; yet they would fall back to sleep when left undisturbed. Trifluopromazine by the drip method appeared to alter reactions to pain. During the first six postoperative hours, only 26 per cent required any narcotics. In the entire series, only one patient had postoperative nausea and vomiting although the day following the operation, ten patients did recall fleeting episodes of nausea that passed in a moment.

The outstanding side reaction was a mild hypotension in 62 per cent of the patients. This hypotension was alleviated by elevating the foot of the bed and by using vasopressors.

Patients who did develop hypotension had dry skins, a good pulse pressure and appeared normal to all observers.

Respiratory depression was not observed. Amnesia was discovered in 76 of the hundred patients. Many carried on perfectly rational conversations postoperatively; yet could recall nothing of the first twelve hours after their operation.

CONCLUSIONS

Trifluopromazine (20 milligrams in a liter of 5 per cent glucose in water) proved a valuable agent in reducing postoperative complications from surgery and anesthesia. Nausea and vomiting were eliminated in all but one patient during the first six postoperative hours. Although appearing to have less sedative properties than other phenothiazine derivatives, it did maintain patients in a light state of slumber. Amnesia appeared to exist in 76 per cent of the patients in this series.

TABLE 1.

REACTION TO TRIFLUOPROMAZINE DRIP AFTER GENERAL ANESTHESIA

Agents Used	No. Pts.	Nausea	Vomiting	Retching	Amnesia	Pain Requiring Narcotic		Hypotension
C H	21	0 (0%)	1 (5%)	0 (0%)	15 (61.1%)	8 (38 %)	(71%)	15
Ether	6	0 (0%)	0 (0%)	0 (0%)	6 (100 %)	1 (16 %)	(50%)	3
N O Ether	10	0 (0%)	0 (0%)	0 (0%)	5 (50 %)	4 (40 %)	(20%)	2
C H Ether	63	0 (0%)	0 (0%)	0 (0%)	50 (79.5%)	13 (21.6%)	(60%)	42
Totals	100	0	1	0	76	26		62

TABLE 2.

CONTROL SERIES

Agents Used	No. Pts.	Nausea	Vomiting	Retching	Hypotension	Amnesia	Pain Requiring Narcotic Within 6 Hours
C H	20	4 (20%)	8 (40%)	4 (20%)	12 (60%)	2 (10%)	19 (95%)
Ether	10	4 (40%)	1 (10%)	1 (10%)	2 (20%)	1 (10%)	9 (90%)
N O Ether	17	1 (69%)	4 (23%)	4 (23%)	2 (12%)	0 (0%)	17 (100%)
C H Ether	53	9 (17%)	11 (21%)	8 (15%)	14 (26%)	6 (11%)	50 (96%)
Totals	100	18	24	17	30	9	95

Seventy-four of the hundred had an altered reaction to pain. They required no narcotics during the first six hours postoperatively. Although hypotension increased two-fold, it was not found to be a serious complication.

SUMMARY

A STUDY was conducted on a preliminary series of 100 patients given a liter of 5 per cent glucose in water to which had been added 20 milligrams of trifluopromazine.† Given intravenously postoperatively at a rate of 40 to 60 drips per minute, this was effective in eliminating postoperative nausea and vomiting. Seventy-six of the hundred had an amnesia and required no narcotics during the first six hours. This was deemed highly desirable. The mild hypotension that developed in 62 per cent of the patients was not a serious complication. It was easily controlled.

Pascack Valley Hospital

They Don't Practice What They Preach

In an article in the *Journal of the American Dietitian Association* (35-687, June 1959), a nutritionist with the incredibly appropriate name of Peggy Cooke Fry, reported that she had kept a daily record of the food and drink consumed in a week by 144 girl students of nutrition, ranging from 18 to 25 years. They ate meat, green and yellow vegetables and all kinds of fruit; but they did not choose adequate amounts of other vegetables, potatoes, grain products, eggs or milk. Only 35 per cent of the women had calorie and thiamine intake amounting to 90 per cent or more of the Food and Nutrition Board's recommended dietary allowances. Below this level also were the protein intake of 44 per cent of the women, the calcium intake of 84 per cent, the iron intake of 83 per cent, the vitamin A intake of 25 per cent, the vitamin C intake of 31 per cent, the riboflavin intake of 58 per cent.

Jaguar Joint and MG Miseries

The switch to small cars is producing a new American syndrome, says Strauss* who reports having seen 4 patients in 5 months who had developed pains in the chest, hip and/or back a few days after starting to use a compact car.

"At this stage," adds Strauss, "symptoms began to occur while the patient was driving the automobile or shortly thereafter and were usually relieved by abstinence from driving.

"Cessation of symptoms was never immediate, however, and might require as long as three weeks to subside, because, once the diagnosis was established, the patients were content to live with their discomfort."

Difficulty in operating the small cars is not limited to tall persons Strauss said. Only one of his four patients was more than 5 feet, 10 inches.

Two of the patients had acquired one of the larger imported sports cars with manually operated gear shift and without power steering. The other two were driving one of the new small cars.

The chest pain results from muscles in that area being used in a fashion to which the driver is not accustomed, Strauss explains. The most important cause of the hip and back symptoms is the limitation in footroom due to intrusion of the wheel into the front compartment compelling the driver to sit with the lower half of the body rotated to secure the maximum available space.

"While is is unlikely that the individual practitioner will see many cases of 'Jaguar chest,' 'MG miseries' or 'Corvette hip,' the increasing popularity of smaller automobiles and the renaissance of the gearshift lever should be a warning to the clinician to be on the lookout for new musculoskeletal syndromes."

*Strauss, Jerome F.: May 28, 1960 Journal of the American Medical Association.

Robert R. White, III, M.D.
John K. deVries, M.D.
Summit

Renal Hamartoma (Angiomyolipoma)*

Angiomyolipoma, a rare kidney tumor, is here described and an illustrative, verified, and successfully treated case presented.

Renal hamartoma is classified as a benign tumor of the kidney but probably represents a defect in tissue combination during development rather than a true neoplasm. It was first described in 1883 by Chiari.[1] Since then, it has been variously described as lipomyohemangioma, angiolipoleiomyoma, benign arterioleiomyoma, myoangiolipoma, benign mesenchymoma, and angiolipomyosarcoma. The term hamartoma, or "error tumor," was suggested in 1904 by Albrecht[2] in describing a "tumor-like malformation in which there is abnormal mixing of the normal components of the organ in which they occur."

A review of the current medical literature indicates that the renal hamartoma is a relatively rare tumor. Its actual incidence must be higher, however, judging from the number which are asymptomatic and not suspected during the lifetime of the patient, but which are found incidentally at autopsy. Hamartomas have been described in nearly every organ of the body. They are most frequently found in the lung. The Registry of the Armed Forces of Pathology,[3] reports 52 cases of renal hamartoma up to 1952, only eight of which manifested clinical symptoms. The remaining 44 were found at postmortem examination.

CASE REPORT

A 48 year old housewife was referred for evaluation of an abdominal mass. Two years prior to her present illness, mild hypertension (170/90) was found at routine physical examination and the examiner noted that the lower pole of the left kidney could be easily palpated. Two weeks prior to her present illness, the same examiner noted a large left upper quadrant mass. The patient felt entirely well and denied all urinary symptoms.

Her blood pressure was 180/96, pulse 96, temperature 98.6 orally. Skin was clear and there was no lymphadenopathy. Fundoscopic examination showed slight arteriolar spasm and tortuosity, with minimal arteriovenous nicking. Lungs were clear to percussion and auscultation. A large mass was felt within the left upper quadrant of the abdomen, extending below the superior iliac crest. The mass was smooth, non-tender and easily movable. The liver and right kidney were not palpable. The extremities were normal. Deep tendon reflexes were present bilaterally, with no evidence of peripheral motor or sensory loss.

Admission laboratory data included hemoglobin 13.8 and hematocrit 43. Leukocyte count was 8,700 with normal differential count. Urine specific gravity was 1.008, albumin negative, sugar negative, and micro-analysis showed 3 leukocytes per high-power field. Blood urea nitrogen was 12 milligrams per cent. Intravenous pyelogram (Fig. 1) revealed a space-occupying lesion of the inferior pole of the left kidney with marked flattening and distortion of the internal collecting system. The right kidney was normal. Clinical diagnosis was a primary neoplasm of the left kidney.

Under spinal anesthesia, the left kidney was exposed through a left flank incision, excising the tip of the 12th rib. The kidney and upper ureter were removed with ease without opening Gerota's capsule. The pathologist's report is as follows: "The specimen consists of a surgically resected kidney enclosed in Gerota's fascia. The overall mass measures 12 centimeters in length, and varies from 8 to 11 centimeters in width and from 4-6 centimeters in thickness. The surface consists largely of lobulated fat and zones of hemorrhage beneath a thin, dark membrane. Only a small seg-

*From The Department of Urology, Orange Memorial Hospital, Orange, New Jersey.

Figure 1: Intravenous pyelogram. Large space-occupying lesion of the left lower pole.

Figure 2: Cut section of the gross specimen showing marked distortion of the calyceal system.

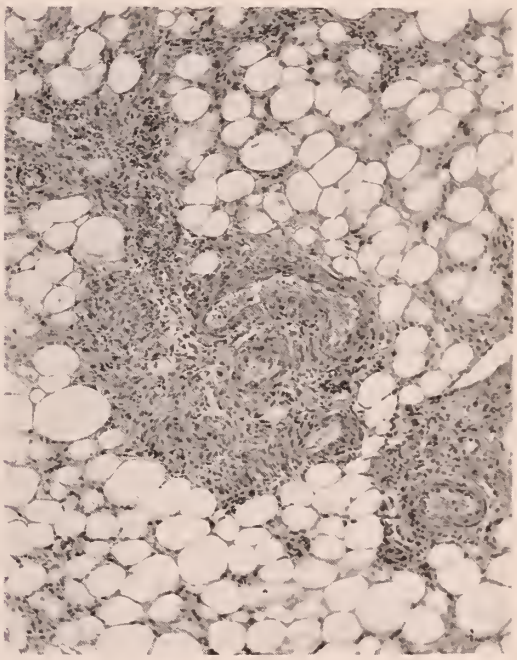


Figure 3: Renal Hamartoma. The characteristic triad of mature smooth muscle, blood vessels, and fatty tissue is seen. Hematoxylin and eosin x 100.

ment of the kidney can be seen through this fascia at one edge of the specimen. A transverse section of the kidney shows two-thirds of the kidney replaced by a soft yellow, fairly well circumscribed tumor mass which extends into the surrounding fat but which is not recognizable from the surface (Fig. 2). This is soft and yellow in appearance, similar to the fat of Gerota's fascia. The preserved portions of the renal parenchyma show a poorly demarcated junction between the cortex and the medulla along with considerable dilatation of the remaining calyces and flattening of the medullary portions of the lower pole. The tumor displaces the calyces but does not extend into the walls of these structures."

Microscopic sections reveal that "the architecture of the kidney is distorted by small to very large foci which are fairly sharply delimited from the surrounding renal parenchyma by a narrow band of pink connective tissue. The foci are composed of fat cells among which are strands and sheets of more dense pink tissue composed largely of bundles of smooth muscle fibers and many blood vessels. The blood vessels are haphazardly arranged and frequently have very thick walls with thickening being predominantly due to an increase in muscular coat. The lumina vary greatly in size but are mostly patent. The smooth muscle bundles and fat show a very intimate relationship (Fig. 3). The tissue extends irregularly into the renal parenchyma with little or no peripheral compression. The parenchyma shows no significant alterations. The calyces are lined by transitional cells. Tissue diagnosis: Angiomyolipoma (Hamartoma or Mesenchymoma)."

The patient's postoperative course was uncomplicated. Her blood pressure fell to 120/80 immediately after surgery and stayed in that range for the remainder of her hospital stay. It was recorded as 160/88 one month postoperatively, however.

Renal tumors cannot be differentiated one from another by observation of a single symptom or group of symptoms. The small isolated cortical lesion, whether benign or malignant, is clinically silent with the possible exception of the hemangioma, which may bleed heavily on occasion. The larger tumors, particularly those of hamartial origin, may suddenly become manifest by massive hemorrhage in or around the tumor. This is not surprising, considering the great vascularity of the hamartoma. The resultant symptoms of sudden severe sharp flank pain, shock, or an enlarging flank mass, may indeed be the first indication of trouble to the patient. Hematuria may or may not accompany these symptoms. The single renal hamartoma is found most often in the lower pole of the kidney. Radiologically, it cannot be differentiated from a malignant tumor or renal cyst. The treatment of choice is nephrectomy.

Moolten[4] has described a renal hamartoma in a 15-year old girl with tuberous sclerosis. Heckel and Penick[5] report a lipomyohemangioma in a healthy 47-year old female with left costovertebral angle pain of 6 weeks' duration. Other reports by Inglis,[6] Hulse and Palik,[7] Morgan *et al.*,[8] Rusche,[9] and Taylor and Genters,[10] note the frequent association of renal hamartoma with tuberous sclerosis and certain allied conditions.

Current statistics indicate that approximately 50 per cent of renal hamartomas occur in patients suffering from the stigmata of tuberous sclerosis. The symptom complex includes mental retardation, epilepsy, adenoma sebaceum, phacoma, and multiple mixed tumors of the kidney. There is usually a familial history. According to Moolten,[4] "lesions of the tuberous sclerosis complex represent a widespread developmental anomaly, often hereditary, in which the primary abnormality lies in the faulty differentiation of tissues rather than of body units (although the latter may be included). The individual lesions represent the characteristics of hamartia or hamartomas, regardless of their situation." Renal hamartomas associated with tuberous sclerosis are usually multiple and bilateral, rarely unilateral. The finding of an isolated hamartoma, however, should indicate a careful search for other stigmata of tuberous sclerosis, not only immediately but at periodic intervals. Some patients have been known to develop tuberous sclerosis years after the diagnosis of renal hamartoma has been made.

SUMMARY

RENAL angiomyolipoma, a relatively rare benign tumor of the kidney, is usually an incidental finding at autopsy. It becomes symptomatic only with marked enlargement and secondary hemorrhage. A frequent association of renal hamartoma with tuberous sclerosis is noted. A case of a large asymptomatic renal hamartoma unassociated with tuberous sclerosis, is reported.

We are indebted to Arthur R. Abel, M.D. and James B. Gere, M.D. of the Laboratory of Clinical Pathology, Orange Memorial Hospital, for their contributions to this case.

129 Summit Avenue

BIBLIOGRAPHY

1. Chiari: Quoted by Hickey, P. M. and Simpson, W. M., citation 12.

2. Albrecht, E.: *Ueber Hamartome. Verhandle, d. deutsch. path. Gesellsch*, 7:153 (1904).

3. Lucke, B. and Schlumberger, H. G.: Armed Forces Institute of Pathology, 30:133 (1957).

4. Moolten, S. E.: Arch. Int. Med., 69:589 (1942).

5. Heckel, N. J. and Penick, G. D.: Journal of Urology, 59:572 (1948).

6. Inglis, K.: Am. J. Path., 26:521 (1950).

7. Hulse, C. A. and Palik, E. E.: Journal of Urology, 66:506 (1951).

8. Morgan, G. S., Straumfjord, J. V. and Hall, E. J.: Journal of Urology, 65:525 (1951).

9. Rusche, C.: Journal of Urology, 67:823 (1952).

10. Taylor, J. N. and Genters, K.: Journal of Urology, 79:685 (1958).

11. Perou, M. L. and Gray, P. T.: Journal of Urology, 83:240 (1960).

12. Hickey, P. M. and Simpson, W. M.: Acta Radiologica, 5:475 (1926).

Bertold Salzmann, M.D.

Linden

Obstetrical "Double Setup" in the Operating Room

This paper is sponsored by the Special Committee on Maternal and Infant Welfare, serving the Administrative Council on Public Health.

In many general hospitals only one obstetric indication is acceptable for transferring to the operating room a patient in the third trimester of pregnancy: cesarean section. The decision is made in the labor room. Once the patient has been placed upon the operating table and the anesthetic administered a point of no return has been reached.

By following this implacable rule, the opportunity for vaginal delivery is definitely withheld. On the other hand, an obstetrician may, knowing that "upstairs" he would have to operate, undertake an ill-advised vaginal manipulation in the delivery room with possibly catastrophic sequelae.

To render good service to the patient, the physician has to be guided by the rule of "safety first." He and the operating room staff must realize that an examination in the operating room will make the final decision as to whether cesarean section is indicated. At least three conditions warrant an examination on the operating room table:

(1) Presumptive diagnosis of placenta previa. No patient should be examined in the labor room, nor in the delivery room if placenta previa is suspected. Only he who has seen a catastrophic hemorrhage resulting from "gently touching" a placenta previa, will accept this dictum.

Whoever examines a patient for placenta previa, must be prepared to operate immediately. Immediately means within minutes! On the other hand many cases of placenta previa may be resolved by simple artificial rupture of membranes. Nobody can foretell which will require surgery and which will be well served by conservative treatment, unless vaginal examination has been done. Not infrequently a prudent physician, to avoid the danger of vaginal examination of a placenta previa in the delivery room, will schedule a cesarean section without knowing whether the patient could have been helped by simple rupture of membranes. He may do this just to avoid argument with the operating room staff.

(2) Whenever a cesarean section is to be done for fetopelvic disproportion, a final vaginal examination in the operating room just before "incision time" may disclose that the patient has solved her own problem and will soon deliver per *vias naturales*.

(3) Occasionally one faces midpelvic arrest in the posterior or transverse position. You may not be sure whether it is safe enough to do a forceps rotation or to resort to cesarean section. He who decides to apply forceps in the delivery room will tend to complete the procedure at all cost, frequently much to the detriment of the patient. The arbitrary

alternative is to transfer the patient to the operating room for cesarean section. However, if the patient is admitted to the operating room for "double setup" with possible forceps delivery *or* cesarean section, then the opportunity exists to use forceps tentatively and to desist immediately if difficulty is encountered. Lithotomy position is then changed into prone position and a second table with laparotomy instruments used. On the other hand forceps rotation to an occiput anterior position may frequently abolish "positional dystocia" and result in a very simple vaginal extraction.

It should be readily understood that admission of a pregnant or parturient woman to the operating room would not necessarily mean cesarean section, but intelligent evaluation of the situation and choice of a procedure which is safest and best suited to the case.

We buy life insurance and hope to live; we buy accident insurance and hope that accidents will never strike; we buy fire insurance and hope never to see fire. It is only reasonable to give the patient and the physician the comfort of the "operating room insurance," hoping that surgery will not be necessary.

46 Gesner Street

Oral Poliomyelitis Vaccine

A strong possibility that oral poliomyelitis vaccine given to a segment of the population could effectively vaccinate the entire nation was suggested by Tulane University researchers in the August 22 (1959) Journal of the American Medical Association. They say that the immunity gained from the vaccine could be passed on from one person to another. It appears that the immunity a child would receive from the oral vaccine can be passed on to other children, ultimately immunizing the entire community.

The viruses were weakened to the point where they could not cause polio but would stimulate the body to set up defenses against the viruses. The result is an immunity to polio just as if a person had contracted the disease and recovered.

The 56 families engaged in the study had all previously received Salk polio vaccine and were divided into groups according to social and economic levels.

The oral viruses were provided by Dr. A. B. Sabin, of the University of Cincinnati, and were administered in the home by members of the staff by squirting the virus in the back of the person's mouth, after which they were given a glass of water.

The results showed, "All except one adult became infected after the feeding of at least 100,000 infectious units, and transmission to many contacts was detected." Curiously, the one variable which played a role in controlling the extent of transmitting immunity was social and economic status.

"Only nine per cent of susceptible contacts from the upper economic group became infected as contrasted with 53 per cent among households from the lower economic groups," he said.

Family Frictions

At the annual meeting of the British Medical Association in Edinburgh London psychiatrists agreed that it was not a bad thing for children to see their parents quarrel in a civilized way and make up. "If inoculated with small doses of parental disharmony, children become immunized and realize that this kind of thing can happen in marriage." Concealment of parental disharmony, said Dr. Stafford-Clark, might result in a buildup of tensions. "If parents can quarrel and make up in front of the children their marriage will stand a better chance and the children will grow up to realize that minor quarrels do not lead to divorce."

Foreign Letters. *J.A.M.A.*, Sept. 26, 1959.

Dryden P. Morse, M.D.

Michael Ramundo, M.D.

Theodore R. Keith, M.D.

Passaic

Correction of Mitral Insufficiency by Open Heart Surgery*

Long resistant to surgical technics, mitral insufficiency now often yields to open heart surgery. Mortality is 15 to 20 per cent, compared with the grave prognosis of trying to treat symptomatic mitral insufficiency medically.

For years, the diagnosis of mitral insufficiency was made whenever there was a systolic apical murmur. It was also easy to form this diagnosis when there were two murmurs (systolic and diastolic) at the apex suggesting the combination of mitral stenosis and insufficiency. Great liberties were taken in making the diagnosis. With increasing experience, however, it was found that mitral stenosis was most commonly "pure." At present, due to the development of an exact radiologic technic for confirming the diagnosis, and for quantitating the degree of regurgitation, it has become possible to put the diagnosis of mitral insufficiency on a firm and exact basis. Mitral insufficiency is now a shining newcomer in the field of cardiac surgery. In recent years, with the availability of open heart surgery, it has become possible to correct this lesion effectively.

Mitral insufficiency is found in about one-third of all patients with mitral valvular disease. Of the patients in whom a major mitral insufficiency is present, about half have it as a "pure" lesion without stenosis. Half of the patients with mitral insufficiency need surgery because of incapacity due to the lesion. The average patient with mitral insufficiency is in his 30's; the lesion is slightly more common in men than women.[1]

The most common cause of mitral insufficiency is rheumatic involvement of the heart. Other causes include congenital malformations of the valve, particularly a cleft in the septal leaflet (commonly associated with atrial septal defects of the primum type) subacute bacterial endocarditis complicating an old rheumatic involvement of the valve; and "functional" mitral insufficiency due to hypertension, or left ventricular dilatation with failure.

PATHOLOGY

There are two major pathologic types of mitral insufficiency. In one, the valve is extensively involved with fibrosis, thickening, shrinking, and *retraction* of valvular and subvalvular structures. There may be calcification and commissural fusion as well. In the second type, the predominant pathologic feature is *di-*

*From the Passaic County Cardiovascular Unit and Passaic General Hospital.

latation of the mitral annulus. This type is but slightly less common.

The area of leaflet overlap or contact during normal valve closure is greater at the anterior commissure. As the two leaflets shrink (or as the annulus dilates) insufficiency first appears, therefore, at the posterior commissure. As the chordae fuse to each other and fore-shorten, the mural leaflet, especially, tends to be drawn down lower than the septal leaflet and to be retracted toward the heart wall. This may result in an insufficiency in which the regurgitant jet sweeps over the mural leaflet. This is the most common type of rheumatic mitral insufficiency.

The second type of mitral insufficiency, which is due to dilatation of the mitral annulus is commonly also associated with minor involvement of the valve. The muscular and fibrous annulus is weakened by rheumatic involvement and in some cases there may be rheumatic myocarditis in the left ventricle. As the valve becomes somewhat insufficient, the left ventricle dilates to compensate, and this results in more mitral insufficiency. In the normal valve, there is some contraction of the mitral annulus during systole.

Many patients with rheumatic myocarditis develop functional mitral insufficiency during the acute rheumatic attack. Some patients with mitral stenosis represent an evolution from insufficiency to stenosis. In fibrous ankylosis of the valve, some mitral insufficiency cannot result in further annulus dilatation owing to the considerable scar tissue in the valve leaflets and in the annulus. Stenosis may be present at the anterior commissure, with insufficiency at the posterior commissure due to retraction of the mural leaflet particularly. In another type of combined mitral stenosis and insufficiency, both commissures are fused down to the classical fixed "fish-mouth" type of orifice where there are irregular pinnacles of calcium along the valve edge, and the valve itself is so stiffened that it has become relatively immobilized with an aperture of only "one finger" in size. Through this aperture there is a regurgitation during ventricular systole, and forward flow (with a gradient) during diastole.

PHYSIOLOGIC STUDIES

THE actual amount of mitral regurgitation is determined by the combination of two factors: (a) the area of the mitral orifice which is not closed during systole; and (b) the pressure relation (gradient) between the left ventricle and the left atrium. A leak of up to 10 cubic centimeters per beat is considered relatively insignificant whereas 20 to 40 cubic centimeters per beat is a major handicap. A leak of over 30 to 40 cubic centimeters will eventuate in death. Mitral insufficiency is compensated for by the heart in three ways: *First,* by reduction in the cardiac output through the aorta; *second,* the left atrium compensates for the mitral insufficiency by an increased atrial contraction early in the disease. *Third,* the left ventricle compensates for the insufficiency by an increase in size. This allows it the capacity to force some blood into the atrium at the same time that some is ejected into the aorta. In some patients the compensation is complete only at rest; with exercise there is an increased diastolic pressure in the left ventricle.

Late in the disease there may be an increase in the pulmonary artery and right ventricular pressure. Right ventricular pressure rises may be followed by right ventricular failure and peripheral signs. The pulmonary vascular resistance is usually lower in mitral insufficiency than in mitral stenosis.

The sudden production of mitral insufficiency, whether produced surgically or by the rupture of a chordae tendinae as in violent effort, may result in pulmonary edema and, commonly may precipitate death.

DIAGNOSIS

ONE-HALF of the patients with a murmur due to mitral insufficiency are asymptomatic. In most of these there is only slight hypertrophy of the left ventricle. The common early symptoms of mitral insufficiency are palpitations and dyspnea on exertion. The palpitations are due either to extra systoles or to the so-called "hyperdynamic" action of the left ventricle; the dyspnea is explained by venous congestion in the lungs as in mitral stenosis.

Heart failure, once it develops in mitral insufficiency, becomes rapidly and progressively worse. This is in contradistinction to the characteristic history of heart failure in mitral stenosis which may be intermittently present over many years.

The development of subacute bacterial endocarditis on the valve involved in mitral insufficiency is not uncommon. As a result, a patient who has had a mitral insufficiency murmur for a long time, may become symptomatic. Acute pulmonary edema is much less common than in mitral stenosis, and hemoptysis is only about half as common. Embolism likewise is less prominent, apparently because there is less stasis of blood in the left atrium. Nevertheless, 70 per cent of the patients with mitral insufficiency do have atrial fibrillation which is one of the factors in stasis and the production of thrombosis in the left atrium.

One of the most prominent symptoms in the fully developed case of mitral insufficiency is *fatigue*. Fatigue almost invariably accompanies the enlarged heart of mitral insufficiency. It is not so prominent in mitral stenosis where the patient is more restricted in his activity by his dyspnea. Another symptomatic differentiation between mitral stenosis and insufficiency is that orthopnea is not as common in mitral insufficiency as it is in mitral stenosis, and the patient characteristically can be flat without discomfort until the end approaches.

When, late in the course of disease, right ventricular failure develops due to increased pulmonary pressures, there is enlargement of the liver, ascites, venous enlargement and peripheral edema. Hoarseness may also be found as in mitral stenosis, due to compression of the recurrent laryngeal nerve by the enlarged pulmonary artery.

THE most striking *finding* in mitral insufficiency is the systolic murmur at the apex. This is best heard with Bowles type, flat diaphragm stethoscope. As a rule, the systolic murmur is higher pitched than aortic valvular and ventricular septal defect systolic murmurs, and may be differentiated (by its timing, etc.) by phonocardiogram from these murmurs (Fig. 1). Because the regurgitation into the atrium starts before the aortic valve opens (*i.e.* at a lower pressure than the output into the aorta) the systolic murmur starts earlier and ends later than the murmur of aortic stenosis. The murmur of mitral insufficiency thus overlaps both the first and second heart sounds. The first heart sound may be obliterated to the examiner by the systolic murmur. The systolic murmur may be high-pitched ("seagull" type murmur). The murmur may be distinguished from the murmur of tricuspid insufficiency by the fact that the intensity of the murmur is less on a long inspiration followed by apnea. Most of the murmurs of mitral insufficiency are accompanied by a thrill which will be particularly prominent if the insufficiency is due to a ruptured chordae tendinae. In many of the patients with mitral insufficiency, even though there is no large element of stenosis, there is a short, early, *diastolic* murmur as the regurgitated blood is returned from the atrium into the ventricle (this can be thought of as a "*relative stenosis*" to the increased forward flow). There also may be a third heart sound, due to the sudden filling of the ventricle and this can be distinguished on the phonocardiogram inasmuch as it is much later than the opening snap of the mitral valve which is heard in mitral stenosis. There is no opening snap in mitral insufficiency. The pulmonary second sound is accentuated and split in the patients who have pulmonary hypertension.

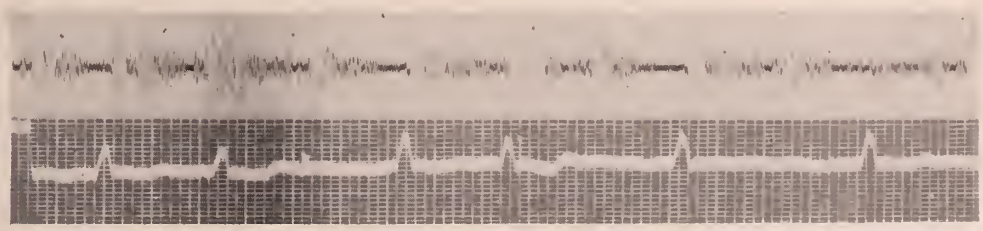


Figure 1. Heart sounds in a patient with severe mitral insufficiency. Note the early diastolic murmur in some areas.

About 5 per cent of the patients with mitral stenosis with definite but minimal mitral insufficiency (as felt by the surgeon's examining bare finger) have had no systolic murmur heard pre-operatively!

Of great diagnostic importance is the presence of a *precordial heave* with mitral insufficiency. Due to the dilated left ventricle, the thrust upwards of the heart in systole is prominent and serves as a differentiating factor from mitral stenosis in which the precordium is quiet. The heave may be prominent in the sixth intercostal space, far laterally.

Atrial flutter and fibrillation with tachycardia are common in mitral insufficiency and if the tachycardia does not respond to digitalis, it is most suggestive that in a patient with combined mitral stenosis and insufficiency type of murmur, the mitral insufficiency is indeed significant.

X-ray changes: The most prominent features in the x-ray are enlargement of the left ventricle and left atrium. The enlargement of the left ventricle distinguishes mitral insufficiency from mitral stenosis. The enlargement of the heart in the PA view shows the left ventricle extending to the left in the area of the apex of the heart. The left atrium may also be prominent even in the PA view, and extend out on both sides of the heart. Mitral insufficiency is the condition in which the most gigantic or aneurysmal atria are found. In the right anterior oblique view, the enlarged left atrium is seen pressing posteriorly against the displaced esophagus. A differential sign (according to Sosman and Dealy [14]) is the type of enlargement of the left atrium which extends posteriorly all the way down the esophagus, producing one large continuous bulge against the esophagus.† In contrast, in mitral stenosis in most patients, there is a localized bulge against the esophagus in the middle portion only of the posterior heart shadow, Thus, the configuration of the esophagus in mitral stenosis is more like a question mark with a bulge and then a straight line down to the diaphgarm.

The pulmonary vascular markings are increased in mitral insufficiency, but the pulmonary artery is not usually as enlarged as in the advanced case of mitral stenosis.

On fluoroscopy, the systolic expansion of the left atrium can occasionally be made out in the early case, although when the atrium is much dilated, it may be absent. This systolic pulsation of the left atrial position of the heart, which is "paradoxical" in timing, may also be shown by roentgen kymography. There is an early rise and a flat top to the atrial expansion curve.

Electrocardiograms: In the advanced case, there will be left axis deviation. This is in distinction to mitral stenosis, in which such deviation is not found. In the precordial leads, the left ventricular hypertrophy will be clearly shown. The P waves tend to be large, although not as conspicuous as in mitral stenosis. The absence of left ventricular preponderance does not mean mitral insufficiency is not present. More than half of the cases of regurgitation show none.

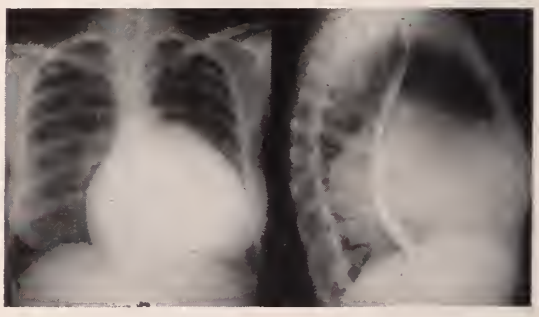


Figure 2. X-ray views of a heart in far-advanced mitral insufficiency. The huge left atrium contributes to the balloon-like shape of the heart.

Catheterization data: On right heart catheterization the pulmonary arterial pressures are usually not greatly increased, nor is the pulmonary vascular resistance in most cases. The wedge pressure may show a reflected "CV" wave, although the height of this wave is not well correlated with the amount of mitral insufficiency. The same type of wave can be seen on the direct left atrial catheterization by the Bjork transthoracic or the bronchial left atrial puncture technic. In far advanced cases there is so-called "ventricularization" of the left atrial curve. Thus during systole the left atrial pressure mounts up to closely follow

†See figure 2.

the left ventricular pressure curve, although not as high. In mitral insufficiency it is frequently difficult to advance the catheter into the left ventricle and to maintain it there: almost diagnostic, this is known as the "washout" phenomenon. The tip of the catheter, although introduced into the left ventricle is forced back into the left atrium with each systole.

Angiographic studies: Injection into the pulmonary artery in mitral insufficiency with cine-roentgen studies will show a "ping-pong" effect of the dye between the left atrium and the left ventricle, before the head of the column of dye passes on into the aorta. There is also delayed retention in the left atrium, the large size of which can be clearly seen, but not as much delay and retention as in mitral stenosis.

Ventriculography: Perhaps one of the most exact technics for measuring mitral insufficiency is the direct injection of radio-opaque dye (90 per cent hyopaque) into the left ventricle by either the trans-apical technic or the subxiphoid site in which the needle is advanced through the right ventricle, through the ventricular septum and into the left ventricle. Following the method of Sones [2] we have also used a retrograde aortic catheter passed from the brachial artery back through the aortic valve into the left ventricle. Such injection of dye followed by serial films (or cine-angio studies) can quantitate the amount of regurgitation present. Dye dilution tests and the injection of radioactive isotopes into the left ventricle with peripheral and left atrial sampling studies may also be emphasized to quantitate the degree of mitral insufficiency.

Clinical diagnosis: The clinical diagnosis of mitral insufficiency is based upon the murmur, the history of rheumatic fever, and the enlargement of the left ventricle and the left atrium on x-ray. A history of subacute bacterial endocarditis or a penetrating or nonpenetrating chest injury, may also be compatible with mitral insufficiency.

Calcification of the valve on fluoroscopy is a valuable clue to the origin of a systolic murmur. The murmur of mitral insufficiency should be differentiated from functional "hemic" murmurs, particularly those originating in the pulmonary artery, which usually are of the lesser degrees of intensity. These frequently will disappear if the patient is asked to hold his breath in deep inspiration.

Cardiac enlargement is the chief indication that the systolic murmur which is heard is of "dynamic" significance. Systolic murmurs may also be heard in anemia, hyperthyroidism, hypertension, and subacute bacterial endocarditis on other valves. Finally, a *changing* systolic murmur should make one suspect the diagnosis of myxoma or cardioma of the left atrium causing varying degrees of mitral insufficiency as the tumor mass enters the valve orifice to varying degrees in different positions.

PROGNOSIS

THE usual history of the patient with mitral insufficiency, unlike the history of the patient with mitral stenosis is that the murmur of the mitral insufficiency becomes well established during the period of active carditis. There is thus no latent interval, as there may be in mitral stenosis, before the murmur becomes apparent. Usually in the mitral insufficiency patients, there is no change until either left ventricular failure occurs, after which the patient goes down-hill fairly rapidly; or until reactive pulmonary hypertension is caused. In mitral insufficiency, there will be about five years from the time serious failure first appears before total incapacity occurs. In mitral stenosis, the corresponding figure is eight years. The average age of death of mitral insufficiency is about the same as in mitral stenosis, or slightly less. It may be that the average age of death in rheumatic mitral insufficiency is earlier than in stenosis, but that the statistical average is raised because of the inclusion of mitral insufficiencies due to such causes as left ventricular failure due to hypertension, coronary artery disease, or aortic valvular lesions.

The two distinct types of mitral insufficiencies run a different clinical course. In one type there is a murmur with no cardiac enlargement. This patient does well for many years unless subacute bacterial endocarditis intervenes. In the other type, the patient, when

first seen, has symptoms of either early or fully developed failure. The devolutionary pattern of this disease is fairly rapid in timing and progressive in severity; surgery should be recommended as early as possible.

OLDER OPERATIONS

SEVERAL surgeons have attempted to relieve mitral insufficiency by closed technic but without much success. Bailey[3] devised an ingenious procedure in which a pericardial sling or hammock was suspended across underneath the area of regurgitation to block it. Harken[5] similarly inserted a synthetic prosthesis underneath the valve. In both these operations, the substance inserted tended to break loose, or for some reason (*e.g.* scarring and shrinkage) did not remain in the area to be blocked. Davila and Glover[4] devised a "closed" circumscription of the mitral annulus. In this operation a curved needle followed by a heavy suture was threaded through the substance of the "annulus" or just outside it, around the entire mitral orifice. The whole valve was purse-stringed. This procedure was ineffective, however. One reason was the absence of the mitral annulus in the area behind the septal or aortic leaflet where the aorta comes out of the ventricle. Another difficulty was that the suture cut through due to the constant stress upon it. The procedure was not suited to the fibrotic and calcific valve in which some element of stenosis as well as insufficiency was present. (Lacerations of leaflet substance are, of course, best repaired by resuture of the laceration.)

MODERN SURGICAL REPAIR

ALTHOUGH Nichols,[6,7] as early as 1955, using a closed technic, was able to suture the mitral annulus across the posterior pole of the valve placing the sutures from outside the heart which effectively abolished mitral regurgitation, it was not until the availability of open heart surgery that this method could be applied safely in patients with severe mitral insufficiency.[8,9,10,11]

The patient with severe mitral insufficiency may now have his lesion corrected surgically by a variety of technics depending upon the pathology found at operation. Annulus cross-plication or shortening has been supplemented by the use of plastic materials to increase the amount of valve substance, and by the ability to suture directly a torn leaflet or a ruptured chordae tendinae if such is the nature of the pathology.

The risk: In mitral insufficiency, the risk of surgery depends on the pre-operative functional heart classification of the patient. If the patient is in Class IV (symptoms at rest and with full medical treatment) the risk of surgery is severe (30 to 50 per cent mortality). This is due to the fact that the left ventricle is dilated and severely strained. Although the valvular lesions may be repaired, the ventricle may not be able to withstand the change in the dynamics of the circulation and the shock of the operation.

If there is any degree of aortic insufficiency as well as mitral insufficiency, the risk of the operation is also much increased (30 to 50 per cent) even though the patient is not a Class IV. Aortic insufficiency makes the repair of mitral insufficiency technically difficult because of the leakage of the perfusion blood back through the aortic valve into the operative field. The aortic insufficiency, if untreated, also puts an added strain on the left ventricle.

The risk of surgery in the minimally symptomatic with mitral insufficiency is now 10 to 20 per cent.

It is expected that this risk will decrease with increasing experience in the technics involved in repair. The death of patients in this favorable group is due to technical hazards of bypass including air embolism, bleeding tendencies, renal shutdown, transfusion reaction, subacute bacterial endocarditis, and the presence of undetected active myocarditis, as well as the pre operative state of the myocardium and other results of the long standing mitral insufficiency in the patient.

The *average* mortality in patients with mitral insufficiency who are treated by open technic at the present time is 15 to 20 per cent.

It is this high because only the more seriously ill patients are being referred for surgery; and because technics of repair of this lesion are still in their developmental stage. This figure largely derives from the experience of Nichols[7] in over one hundred patients at the Hahnemann Hospital in Philadelphia. Although the number of patients operated by his method at the Passaic unit have been few, the results in terms of the abolition of murmurs, functional improvement, and so on, have been excellent. A follow-up study of these patients is now being undertaken.

RESULTS OF OPERATION

IN MOST patients who are operated for mitral insufficiency by an open technic, the lesion is abolished. This has been shown by ventriculography. The patients are improved correspondingly and dramatically. They are able to return to a functional life with a minimum of symptoms. The heart size has shown a marked reduction in most cases. The majority of the Passaic patients although previously incapacitated, have been able to return to a useful life.

SUMMARY

MITRAL insufficiency is a lesion which is now relatively easily diagnosed clinically. It can be confirmed and quantitated by ventricular injection of radio-opaque dye in patients in whom surgery seems indicated. The risk[13] of such a dye injection in seriously ill patients is about 1 per cent. The study should not, therefore, be undertaken lightly. Surgery for mitral insufficiency has now grown out of its infancy, but the mortality is still appreciable. However, on the medical side, the prognosis for a patient who has developed left ventricular failure with mitral insufficiency is grave (5 years). The usual course is rapidly downhill due to the vicious cycle of regurgitation, left ventricular dilatation and resultant increase in insufficiency. Improvement in open heart technics of bypass and in surgical methods of correction of the individual types of pathologic lesions causing insufficiency will result in a further decrease in the still appreciable operative mortality. One of the most important reductions in the mortality will be the referral of patients who have serious and increasing mitral insufficiency at an earlier stage before irreversible left ventricular dilatation and failure has occurred. The future of operative treatment for such patients is bright.

350 Boulevard

BIBLIOGRAPHY

1. Wood, P.: Diseases of the Heart and Circulation, 2nd Ed., Pps. 502-515, Lippincott, Philadelphia (1956).

2. Sones, M.: Personal communication to the authors.

3. Bailey, C. P. *et al.*: Journal of Thoracic Surgery, 28:551 (1954).

4. Darryl, J. C. *et al.*: Journal of Thoracic Surgery, 30:531 (1955).

5. Harken, D. E. *et al.*: Journal of Thoracic Surgery, 28:604 (1954).

6. Nichols, H. T.: Journal of Thoracic Surgery, 33:102 (1957).

7. Nichols, H. T. and Bailey, C. P.: Encyclopedia of Thoracic Surgery; Volume 2. Page 834. (Editor: E. Derra). Springer-Verlag, Berlin (1959).

8. Sinha, K. *et al.*: American Journal of The Medical Sciences, 237:78 (1959).

9. Murphy, D. R. *et al.*: Journal of Thoracic Surgery, 37:320 (1959).

10. Effler, D. B. *et al.*: Journal of Thoracic Surgery, 36:665 (1958).

11. Kay, E. B. *et al.*: Journal of Thoracic Surgery, 36:677 (1958).

12. Kay, E. B.: Surgical Treatment of Mitral Insufficiency. Presented in Philadelphia at American Heart Association, October 24, 1954. In press.

13. Morse, D. P.: Unpublished data on 300 cases studied at the Hahnemann Hospital, Philadelphia.

14. Dealy, J. B.: New England Journal of Medicine, 254:825 (1956).

NELLIE D. STONE, M.S.W.
East Orange

A Community Clinic for the Retarded*

The retarded boy or girl is the step-child of medicine, pedagogy, psychology, psychiatry and pediatrics. Few handicapped people have been so ignored, so neglected. Mrs. Stone tells us here of one agency aimed at providing some help for this unfortunate but potentially useful group.

THE Guidance Clinic for the Retarded, established in 1949, was one of the first specialized community facilities for clinical evaluation of the problem of mental retardation and guidance for parents. At the beginning, psychiatrists, pediatricians, psychologists and social workers were designated by their own professional groups to provide volunteer services. A neighborhood house furnished the quarters; and the Essex Unit, New Jersey Association for Retarded Children, provided material supplies, impetus and clientele for this new program. The clinic is the hub around which auxiliary programs of training and recreation for the retarded have been built. To insure sound professional practice and policy, a professional advisory committee was set up as liaison between the sponsoring organization and the clinic operation.

During the past ten years, the clinic increased its services and developed its staff to full-time positions for a clinic administrator, clinical psychologist, and clinic social worker, in addition to clerical personnel. It also added a part-time medical director, and has expanded its staff of examining pediatricians to seven, with auxiliary neurologic, psychiatric and other consulting specialists. During the past year, over 400 mentally retarded individuals and their families were given diagnostic and guidance service. The clinic is supported by patient fees, on a sliding scale, community contributions to the Unit's annual campaign, and by a grant from State Mental Health Act funds. Service is available to all who need it, regardless of income. The clinic pays each examiner for his services, believing this basis to be fair and sound.

There are now about 75 specialized clinics in the United States in which the mentally retarded child or adult may receive evaluation and guidance. Much of this recent development has been possible through the Maternal and Child Health Program, financed by grants from the United States Children's Bureau to State health departments for the purpose of setting up demonstration programs in retardation. In New Jersey, three clinics are concerned with mental retardation: the Retarded Children's Clinic at St. Mary's Hospital in Passaic; the Child Evaluation Clinic at Morristown Memorial Hospital; and our own clinic which (though not hospital-based) has access to many local hospital facilities on an out-patient basis. Each of these clinics operates on the principle of team work in a clinical setting, in which medical, social and psychologic disciplines are brought to bear upon the problem. Also involved are educational, recre-

*Presented at a Symposium on Retardation before the Pediatrics Section, Annual Meeting of The Medical Society of New Jersey, May 18, 1960, Atlantic City, New Jersey. Mrs. Stone is Director of the Clinic for the Retarded in East Orange.

ational and other community services for the retarded and their families as part of the overall planning.

CHILDREN or adults of any age who are suspected of being mentally retarded may be referred to the Guidance Clinic for study from a wide variety of sources, such as physicians, health or community agencies, schools, or friends. We are particularly interested in receiving referrals from pediatricians or other physicians who care for children. One of our main purposes is to be of assistance to the physician in the handling of his patient through furnishing specialized diagnostic evaluation. Over one-third of the children studied are directed to our clinic by physicians, hospital clinics or other health organizations. We would like this proportion to increase, since we have found that medical referrals are a sound basis for clinical service.

The study process begins with an interview between the parents and the clinical social worker, who obtains the parents' impressions about the child's development, functioning, and problems, as well as a detailed account of previous professional consultations, with permission to secure direct medical, psychologic and school reports. The family physician is always notified that clinic study has been applied for. His assistance is enlisted in providing facts about medical treatment and findings. The social worker then organizes this history and her own observations of family relationships and attitudes into a summary to provide other examiners with a background for their own evaluations.

The child is next seen by the clinic psychologist for measurement of his performance and capacities as indicated by responses to psychologic testing and evaluation. His observations as to the child's emotional reactions and social maturity are also included, along with indications of possible visual-motor or organic dysfunction in his report. All this is made available to the medical examiners.

The pediatrician's examination is of prime importance in bringing into focus his broad experience with deviations in childhood development toward a diagnostic impression of the medical classification. The pediatrician reviews birth and hospital records, medical reports and the parent's account of the child's history, adding his own observations to make up his report, which may contain suggestions about further diagnostic procedures or treatment. When indicated, additional out-patient examinations are arranged with specialists in neurology, psychiatry, x-ray, ophthalmology, and so forth, who act as consultants for the clinic. No medical treatment is done. This responsibility remains with the family physician. If hospitalization is required for completing the diagnostic evaluation (as happens in rare situations) such a recommendation is referred to the family physician to work out.

Speech evaluation may be arranged with the clinic's speech consultant, who determines whether speech therapy is indicated, or whether poorly developed speech is related to the child's retarded mental, physical or social status. Suggestions are given to the parents about stimulating speech development through home or group technics.

WHEN all examinations are completed, the clinic staff meets as a team to review and integrate their impressions, attempting to arrive at a diagnostic conclusion which specifies the degree of mental retardation and the cause, if known. Some idea of the child's capability for training and special education is arrived at, with specific suggestions as to his readiness for group or class experience. The needs of the parents for interpretation and guidance are assessed, with consideration given to the best means of providing it. Finally, the results of the clinic study are summarized and approved by the Medical Director. This summary of impressions of clinic examiners, history, team conclusions and recommendations then becomes the official clinic record of the study, and is available to qualified professional personnel for use in helping the retarded child or his family.

A next, important step is the discussion with

the parents, following completion of diagnostic study. At this time, a staff member reports to the parents the essence of the team conclusions, discussing specific means of carrying out suggestions for the care or training of the child. Parents are referred to their own physician for any detailed discussion of medical findings or recommendations. The clinic staff member tries to give the parents an integrated idea of the child's status, diagnostic impressions, psychological, educational and social factors, and total outlook for the child. A further aim is to assist the parents to examine their own reactions to the child and his limitations, as reflected in their experience in handling him, and in the impressions of the clinic study. The ultimate goal of the follow-up conference is to assist the parents to achieve a realistic understanding of their child's capacities, helping them to move along toward constructive handling of him within the family, or planning for his training or care outside the family.

THE clinic worker's knowledge of and access to special community programs for the retarded child enables him realistically to augment and implement the indications of the basic clinical evaluation. For example, if a child is felt to be ready for nursery experience, as a means of furthering social development and speech, the child may be enrolled in one of the three pre-school classes sponsored by the Essex Unit of the New Jersey Association for Retarded Children. Similarly, recreational opportunities may be provided through the Unit's summer day camp, swimming program, teen canteen, or a scout troop. In cooperation with the Rehabilitation Commission, a plan of vocational training, which may lead to sheltered employment, is possible through the Occupational Center of Essex County, of which the Essex Unit is one of the sponsors. Not only the special programs of the Essex Unit, but also other services made available by the community or state are utilized for the retarded child by referral to public special classes or institutional care, either public or private. The clinic worker can be of particular assistance to the family physician by helping the family find appropriate placement facilities. The needs of parents for continued support and counseling in carrying out a realistic program for their retarded child may be met through periodic, individual interviews with a clinic staff member, or through participation in clinic counseling groups. If a family's social problem goes beyond the function of this clinic, help is sought for them through other community casework or welfare services. Likewise, health needs which require special handling, may also be served through hospital treatment clinics, or other special health services, after clearance with the family physician.

The medical program of the clinic includes a routine check of the urine of each patient for indications of phenylketonuria. During the past five years twelve cases have been discovered in a total of about 1,000 children tested. Since this is higher than the proportion estimated for the general population, the importance of widespread testing, particularly of infants, is indicated. Here is an area in which pediatricians and physicians treating newborn children may play important roles in detection of a metabolic defect for which experimental diet treatment could prevent brain damage and mental retardation.

IN view of the permanent nature of the disability of mental retardation, clinic assistance may be sought at various critical points throughout the child's life. Thus, a case may be "active" or "inactive" successively; but it is rarely completely disposed of throughout the child's stay in the home. Periodic re-evaluations are essential to assess changing needs for the child or family, and to reinforce sound diagnosis and realistic planning. Perhaps the continuing thread throughout the parents' grappling with the problems of mental retardation, is the supportive help provided by membership in the Essex Unit. By coming together with other parents and individuals concerned about this problem, a parent feels less alone, and gradually comes to accept his own child's

situation, and to broaden his outlook toward constructive efforts in behalf of all handicapped children. In the past eleven years parents' associations have developed on a sizable scale throughout the country. Such groups have become an effective force in organizing public interest and support for meeting the needs of retarded children to develop their capacities more fully as worthy members of the community. The theme of the recent White House Conference emphasizes this same principle for all youth.

Reliable estimates place the number of retarded children born at three out of every hundred births. This handicap represents a sizeable group, with which pediatricians and other physicians will inevitably come into contact. The complexities of the condition of mental retardation require special diagnosis and treatment technics. Certainly in New Jersey there is need for more than three mental retardation clinics to assist physicians and other professional groups in the handling of mentally retarded children. The physician, as an important community resource, should be concerned with stimulating the development of adequate facilities for dealing with this problem throughout the state.

100 North Arlington Ave.

Calm Persons May Need Tranquilizers

The emotional and overactive person is no more susceptible to high blood pressure than his calmer contemporary, according to Page,* who said that there are "many highly nervous, overactive persons who don't have any hypertension.

". . . in many patients, the hypertension is coming from the kidneys and not from their nervous systems," he said. "This is an important, newly-discovered facet of the disease." Many whose high blood pressure was believed due to unknown cause actually have a kidney ailment that can be corrected surgically. The kidney is responsible for more hypertension than any other single system of the body.

Page* also pointed out that while the kidney can provoke high blood pressure it can also control it. "It secretes an enzyme which acts on the blood to produce angiotensin. We think angiotensin is the cause of high blood pressure of kidney origin.

"As a protective organ, the kidney has a means of destroying this blood pressure raising principle." Page doubted that there was a close relationship between the incidence of high blood pressure and the strains of modern living.

"What is stress to one person is not stress to another. It is hard to assume that our generation is under more stress than any other generation. There must have been stresses during the Wars of the Roses and it must have been pretty stressful trying to build a pyramid in ancient times."

Hypertension, he said, is well on the way toward being corrected and the causes successfully treated.

*Page, Irvine H.: June 1960 *Today's Health.*

Film on Cluster Testing

A Public Health Service training film, entitled *Cluster Testing** is available to agencies interested in the application of the cluster testing technic. Requests for loan of the film are addressed to the VD Control Program, State Department of Health, Trenton 25, N. J.

*See page 517 of this JOURNAL.

G. Robert Hardy, M.D.

New Brunswick

Bilateral Carotid Body Tumor

In all the world literature, only 287 carotid body tumors have been reported. To this scant collection Dr. Hardy adds two more—both in the same patient. Surgical technic is also reviewed.

The problem of carotid body tumor is serious and the surgical treatment of bilateral carotid body tumor is doubly serious. The incidence of bilateral tumors of the carotid bodies has been estimated at about 3 per cent (Fletcher).[2] According to Morfit,[5] only 287 cases of carotid body tumors have ever been reported. The carotid body normally occurs bilaterally at or near the bifurcation of the common carotid artery. The body has a fibrous capsule. It is divided by septae and contains nerve fibers of sympathetic and parasympathetic origin. Tumors may be attached to the bifurcation of the carotid artery by finer fibrous bands. Sometimes tumors may be "melted" or infiltrated densely into the adventitia of the arteries. The incidence of malignant change has been variously reported from 15 to 50 per cent. It is the general impression that malignancy in these tumors is low.

Carotid body tumors produce minimal symptoms, but do cause pain in the neck or face. Larger tumors may cause pharyngeal pressure resulting in some dysphagia or even dysphonia. There may be a familial tendency as shown by the case presented below. The tumors usually grow slowly. They present themselves in the superior-anterior triangle of the neck projecting from under the anterior border of the sternomastoid muscle. The differential diagnosis rests between branchial cyst, neurofibroma, lymphoma, adenitis, metastatic tumor from a carcinoma of the thyroid, and carotid aneurysm.

The surgical excision of the carotid body tumors would probably not be so hazardous if operative intervention were possible earlier while the tumor was small. This is exemplified in the case below. Surgical excision is the most effective treatment for these tumors. The two specific problems which the surgeon has to cope with are the question of malignancy and the resectability of the tumor. Ideally all carotid body tumors should be completely excised. Smaller, well encapsulated tumors can easily be removed without injuring the carotid vessels. Larger neoplasms invade the adventitia of the carotids and complete removal of these tumors is possible by establishing a cleavage plane in the adventitia, after complete mobilization and control of the common carotid, internal and external carotid arteries, as advised by Lahey and Warren.[6] Recently Morfit, Swan, and Taylor[5] have re-emphasized the unjustifiability of ligating the carotid artery, which causes high mortality and cerebral complications. They prefer the restoration of arterial continuity in one way or another, such as suture repair, anastomosing the internal carotid to the common carotid or even the insertion of a graft.

A 44-year old woman was first seen in February 1956. She said that she had had a swelling in her left neck since 1934. In 1940, a biopsy of the tumor was taken and the diagnosis of a carotid body tumor was made. She seemed to be asymptomatic, and the tumor remained the same size from 1940 to 1950. In the next six years the tumor gradually increased in size. For several months prior to admission to the hospital she had occasional dizzy spells, headaches, soreness of the left neck and a feeling of pressure in the area of the tumor. Her sister was operated on in 1940 for the same type of tumor.

On admission to St. Peter's Hospital in February 1956, her blood pressure was 174/62. The pharynx was narrowed and she had difficulty in swallowing. All of these were attributed to the presence of a 5 by 3 centimeter mass in the superior-anterior triangle of the left neck, as illustrated in Figure 1. A healed short scar over the area made complete palpation of the tumor somewhat difficult. Physical examination (including chest x-ray) was normal. The diagnosis of carotid body tumor was definitely confirmed by the pathology report from the previous operation. On February 28, 1956 at operation the tumor was found to be 5 by 3 by 2 centimeters in size, densely adherent to the bifurcation of the common carotid and its branches.

After complete mobilization and control of the common carotid, internal and external carotid arteries the tumor mass was gradually dissected away from these structures by careful dissection through the adventitia layer (Figure 2). During the procedure the common carotid artery itself was perforated. Bleeding was immediately controlled by several small arterial silk sutures. She had an uneventful course and was discharged on March 7, 1956.

The patient had been followed for 2 years. By August 1958 a small lump had developed in her right neck, at a site corresponding to the tumor on the left side. The only symptoms associated with the tumor were a feeling of "pressure in her neck" and slight dysphagia. This time her blood pressure was 162/80. The tumor mass in the right side of the neck measured 25 millimeters in width and seemed to protrude from under the anterior border of the middle third of the sternomastoid muscle. The left side of the neck presented a well healed oblique scar with some firmness along the upper half of the scar but no evidence of any recurrence of the previously excised tumor. The pharynx still remained narrow and now the right lateral pharyngeal area seemed to bulge more, apparently due to the right sided tumor. The rest of the physical examination (including chest x-ray) was normal. On August 11, 1958 the right carotid body tumor was excised. The tumor was 25 by 25 by 15 millimeters in size and was easily shelled away from the bifurcation of the carotid artery after the common carotid artery and its branches had been mobilized and under control.

Postoperatively the patient has had some dysphagia which is apparently due to hypoglossal paresis which seems to be improving. She was discharged August 17, 1958. Since discharge, she has been seen in the clinic and does not now show definite signs of recurrence of the tumor in her neck. The last chest x-ray reveals an opacity in the right middle lobe. Metastasis is being considered, although the pathologist's report indicated both tumors as being benign.

Figure 1.

Gross appearance of the right carotid tumor.

Figure 2.

Complete mobilization and control of common cartoid artery and its branches showing the attachment of the tumor to these structures.

PATHOLOGY

Microscopic examination of each tumor was similar. They were made up chiefly of epithelial like cells growing in strands and cords which were penetrated at close intervals by small capillaries and venous channels. The cells varied considerably in size and shape. Most of them had abundant eosinophilic cytoplasm. The nuclei varied from large vesicular to the small and hyperchro-

matic type. Occasionally round or oval whorls of cells were found surrounded by vascular channels. Some very dark hyperchromatic giant type nuclei were seen frequently in areas of less obvious rapid growth. Between the nests of cells there were fine fibrous septa and some strands of acellular collagen. Reticulum stain showed an abundance of reticulum, usually running around nests or groups of cells.

COMMENT

THIS patient with bilateral carotid body tumors exemplifies the variability of the tumor in its adherence and infiltration of the carotid bifurcation. The tumor on the left side was densely adherent to the bifurcation and for its removal dissection had to be done in the adventitia of the artery. The tumor on the right side was much smaller and was easily shelled away from the carotid artery through its finer fibrous band attachments. The operator had the firm conviction at the first operation, which involved removal of the densely adherent left carotid body tumor, that the integrity of the carotid bifurcation would be maintained at all cost. At the second operation, the right tumor was removed. However, a synthetic graft was at hand ready for use if the necessity had presented itself. That the right tumor was so much smaller and so much easier to remove suggests the advisability of early removal of the tumors if possible.

SUMMARY

A CASE of bilateral carotid body tumor, successfully excised is presented. The incidence of this type of tumor is discussed. The variability of difficulty in removing it is reviewed as are the two main problems: malignancy and resectability. Maintenance of the integrity of the carotid bifurcation is emphasized. Early excision of the tumor while it is small, if possible, is advised.

255 Suydam Street

BIBLIOGRAPHY

1. Crile, G. and Humphries, A. W.: Am. J. Surg., 94:649 (1957).
2. Fletcher, W. E. and Arnold, J. H.: Am. J. Surg., 87:617 (1954).
3. Friedman, E. W. and Low, R.: Page 633, J. Mt. Sinai Hosp. N. Y. (Oct. 1957).
4. Lemmer, K. E.: Surgical Clin. No. Am., 995 (Aug. 1958).
5. Morfit, H. M., Swan, H. and Taylor, E. R.: Archives of Surg., 67:194 (1953).
6. Warren, K. W.: Surgical Clin. No. Am., 677 (June 1953).
7. Warren, K. W.: Surgical Clin. No. Am., 3:621 (June 1959).

Tranquilizers and Alcohol Don't Mix

A patient taking tranquilizers should avoid also drinking alcohol. So warns Dr. George Zirkle and his colleagues in a report published in the November 14, 1959 Journal of the American Medical Association.

The combination of alcohol and tranquilizers is especially dangerous for people who have to drive cars. The researchers gave the alcohol-tranquilizer combinations to 24 persons who then had to perform a variety of manual tests. All the subjects showed a worse score after taking the combination of the tranquilizer and the alcohol, and the best score after taking a placebo and a soft drink.

It seems obvious that the combination produced dizziness, poor coordination and mental dullness.

Helen E. Jones, M.D.
Robert Barnett, M.D.
Anthony DeSpirito, M.D.

Asbury Park

Acute Leukemia in Monmouth County*

With the increasing use of x-ray, increasing exposure to radio-isotopes and increasing threat of atomic radiation, the problem of leukemia becomes significant. In this simple but effective study, three Monmouth County physicians report on this factor in their area.

For many years it has been the impression of local physicians that acute leukemia was more prevalent in Monmouth County than in other sections of the state and country. With the introduction of atomic experiments and atomic fallout, it was felt that a survey to determine the actual incidence of acute leukemia would be of value. It has been accepted [1] that an increased incidence of leukemia follows exposure to ionizing irradiation.

The locale of the county (along the Atlantic seaboard) made the investigation pertinent because of the possibility of an increased fallout along coastal areas. The population of Monmouth County in 1950 was 225,327; in 1959, it was 343,710. Monmouth County in central New Jersey along the Atlantic Ocean, covers 539 square miles. Most of our people live along the seaboard. There is an extensive farming area in the western portion of the county, where live many large chicken and egg producers.

MATERIALS AND METHODS

An analysis is presented of all deaths in Monmouth County certified as having been the results of acute leukemia during the seven-year period ending on December 31, 1957. There were eighty-three cases investigated.

Criteria for acceptance as acute leukemia were: blood count, bone marrow, biopsy and autopsy. To satisfy acceptance as acute leukemia, at least three of these criteria had to be met. Sixty-one cases satisfied these requirements. Of these, fifty could be classified as to cell type. The hospital records of the county were used as well as personal communications with the physicians of the area.

A questionnaire on personal and family history was completed for each case as well as data relating to exposure to chemicals, x-ray, (diagnostic and therapeutic), radio-isotopes, radium and drugs.

Differentiating "acute" from "chronic" leukemia was difficult and arbitrary. Leukemias are often classified by the dominant cell type, the acute forms showing mostly "blasts" and the chronic more "mature" cells in the peripheral blood. The term *acute* usually implies a short term course characterized by the hematologic picture of immature cells. Patients with a prevalence of blast cells do not always suffer from a rapidly fatal disease.[4] The difficulty in an analysis such as this is that cellular types are given in general terms. When this information is combined with the known duration of the disease, the first classification will clearly have to be arbitrary in a number of cases. These cases run in duration from two weeks to eighteen months.

*The authors are officers of the Leukemia Research Foundation.

RESULTS

THE 61 cases were classified with respect to age, sex and color. The distribution by *age* is reflected in Table 2 and shows that acute lymphatic leukemia is more common in children than in adults. The myelogenous and monocytic types show a similar age pattern—more in the older than in the younger age groups. With respect to *color,* we note that only 2 of the 63 cases were in Negroes, one a 7-year old girl, the other a 46-year old woman. Of the 63 patients, 35 were males.

TABLE 1.

SEX INCIDENCE

	Male	Female	Total	% Male
Myelogenous	8	11	19	42
Lymphocytic	14	7	21	67
Monocytic	7	3	10	70
Undifferentiated	7	4	11	64
Total	36	25	61	60%

TABLE 2.

CLASSIFICATION BY AGE AND TYPE

	Age 0-15	Age 16-40	Age 41-60	Age 61-80	Total Number	Total Per Cent
Lymphocytic	13	1	2	5	21	35
Myelogenous	2	4	7	6	19	32
Monocytic	0	0	5	5	10	16
Undifferentiated or unknown	4	0	2	5	11	17
Totals (No.)	19	5	16	21	61	100%
	32%	8%	26%	34%		

COMMENT

OUR series bears out the findings of other surveys that acute lymphatic leukemia is more common in the earliest age group. Acute myeloid and acute monocytic leukemia are found more often in middle and later life.

In review of the literature, the incidence of all forms of leukemia is believed to be about five cases per 100,000 population *per annum* in Great Britain.[8] In an over-all study of 16 countries the over-all white death rate in the U.S.A. was 10.41 per 100,000 population.[8] All countries had about the same incidence. The incidence of acute leukemia in the United States[2] from 1943 to 1952 was 2.86 per 100,000.

There were 61 cases of acute leukemia in Monmouth County which satisfied our requirements in this 7-year study. This gave us an incidence of 8.71 cases *per annum* or less than 3 cases per 100,000. Thus, our area has about the same incidence of acute leukemia as other locales. If there is an increase in this locale, it is almost negligible.

SUMMARY

FROM the hospital records, death certificates, and personal communications of the attending physicians an effort was made to find out if the incidence of acute leukemia in Monmouth County was greater than of other areas. A total of 83 patients' records were studied; 61 satisfied our criteria for the diagnosis of acute leukemia.

Monmouth County has the same incidence of acute leukemia as do other locales in this country, Australia, Great Britain and Japan.

We are indebted to Herbert Engel, M.D. and Samuel Stine for advice and cooperation in this study.

321 Sunset Avenue

BIBLIOGRAPHY

1. J. Furth & E. Lorenz: Radiation Biology (McGraw-Hill) New York 1954.
2. MacMahon, B. and Clark, D. W.: *Blood*, 11:871 (Nov. 1956).
3. Gilliam, S. A.: *Blood*, 8:693 (October 1953).
4. Meadors, G. F.: Epidemiology of Leukemia. Public Health Reports, 71:103 (1956).
5. Gould, W. R., Innes J. and Roleson, H. N.: British M. J., 1:585 (June 1953).
6. Pinkel, D. and Nefzger, Ph.D. Some Epidemiology Features of Childhood Leukemia in the Buffalo, N. Y. Area—private communication.
7. Fujisakus, Tohoku: Journal of Experimental Medicine, 65:322 (April 25, 1957).
8. Witts, L. J.: British Med. Journal, 1:1197 (May 1957).

Payments Under Medicare

A recent release from the Surgeon General advises that changes in the methods for payments to civilian sources for care to dependents were directed by higher authority. These changes provide that the Congressional appropriation to be charged for authorized medical services will depend upon the date care was completed ("To" date, Item 18, Medicare claim form DA 1863).

Submission of Claims (DA Form 1863)—Payment for services furnished by civilian sources may not be effected prior to the "To" date shown under Item 18, DA Form 1863 (claim). Further, and in keeping with the certification by the source of care in Item 29, DA Form 1863, the date of submission of the claim (Item 28, DA Form 1863) by the source of care should *not* be prior to the "To" date in Item 18 of the claim form. To facilitate proper payment and to enhance the compilation of statistics, it is imperative that sources accurately enter the "From" and "To" dates in each instance. The "From" and "To" dates are intended to reflect the entire periods during which time the civilian source furnished the authorized care (reflected by the claim) to dependents in accordance with the Medicare Program. Fees paid to participating physicians under the Medicare Program for surgical procedures include the following (except for asterisk items in The Schedule of (maximum) allowances whose fees are for surgery only):

A. *Preoperative Care*

(1) *Outpatient Prehospitalization Care*—A minimum of one preoperative outpatient visit prior to hospitalization, but may include additional visits if, at the discretion of the surgeon, he believes more than one visit is included in his fee.

(2) *Inpatient Preoperative Care*—All care rendered by the operating surgeon in the hospital prior to surgery, including consultation(s) and/or examination(s).

B. *Postoperative Care*

(1) *Inpatient Postoperative Care*—That care necessary until the patient may safely be discharged to outpatient followup.

(2) *Outpatient Postoperative Care*—That care ordinarily necessary up to the number of days stipulated in the applicable Schedule of Allowances for the procedure involved.

For detailed information participating physicians should see Medicare Manual and Schedule of Allowances (Surgery, General Information).

Physicians are urged to submit claims for the entire period of care furnished under the Medicare Program as soon as possible after the completion of the services. ("To" date, Item 18, DA Form 1863). Sources of care may, if they so desire, submit partial billings for cases involving long-term hospitalization or services furnished in connection with maternity care (e.g., ante-partum care). However, the practice of submitting partial billings creates additional administrative work, also increases the administrative costs and makes the compilation of accurate and timely statistics more difficult.

Centenary for Dr. Ewen

Dr. Warren L. Ewen of Elmer greeted friends and colleagues this spring who came to congratulate him on attaining the age of 100. The president of the Salem County Medical Society presented Dr. Ewen with a large-print Bible as a memento from his professional brethren.

Dr. Ewen was born in New Jersey seven months before Abraham Lincoln was elected president in 1860. In 1882 he was graduated from Jefferson Medical College of Philadelphia, and from that day on became a typical rural practitioner. In 1910 he did graduate work in ophthalmology at Wills Eye Hospital and became a Diplomate in that specialty in 1913. He retired in 1956 at the age of 96.

Aviation Medical Examiners

The Federal Aviation Agency is interested in finding more physicians who are willing to examine airmen. Those doctors who want to learn more about this important work in aviation and public safety should write to the FAA Regional Flight Surgeon, New York International Airport, Jamaica, L. I., New York.

As of July 1, 1960, the Federal Aviation Agency lists the following physicians in New Jersey as authorized examiners:

Atlantic City
- Dr. Benjamin L. Gordon, 6917 Atlantic Ave. (Ventnor)
- Dr. Maurice B. Gordon, 6917 Atlantic Ave. (Ventnor)
- Dr. Jay E Mishler, 1616 Pacific Ave.

Bloomfield
- Dr. Carl J. Schopfer, 57 Park Place

Camden
- Dr. Milton H. Gordon, 12 N. 27th St.
- Dr. Bascom S. Waugh, 1882 S. Tenth St.

Clifton
- Dr. Peter V. Conserva, 196 Randolph Ave.

East Orange
- Dr. Louis F. Raymond, 719 Park Ave.

East Paterson
- Dr. Mortimer H. Kassel, 34 Elwood Court

Englewood
- Dr. John T. Worcester, 220 Engle St.

Fort Lee
- Dr. Ralph Carbone, 1509 Palisade Ave.

Hackensack
- Dr. Charles P. Campbell, 397 Prospect Ave.

Haddon Heights
- Dr. William D. Kimler, 127 Fourth Ave.
- Dr. Martin E. Swiecicki, 9 Second Ave.

Hasbrouck Heights
- Dr. Thomas K. Bouregy, 163 Terrace Ave.
- Dr. Rudolf Frank, 215 Terrace Ave.

Irvington
- Dr. Alfred J. Krug, 942 Sanford Ave.

Lambertville
- Dr. Henry Dantzig, 12 S. Franklin St.

Levittown
- Dr. Bernard G. Barlow, 2 Surrey Lane

Madison
- Dr. A. Bliss Coultas, 1 Madison Ave.

Maple Shade
- Dr. Richard T. Buckley, 111 E. Main St.

Montclair
- Dr. Allan B. Crunden, Jr., 26 Harrison Ave.

Morristown
- Dr. Albert Abraham, 110 Madison Ave.

Newark
- Dr. R. John Amato, 1134 Broad St.
- Dr. Irving E. Fink, 71 Lincoln Park
- Dr. Aaron H. Horland, 129 Chancellor Ave.
- Dr. Sam Lemkin, 71 Pomona Ave.
- Dr. Samuel L. Pollock, 31 Lincoln Park

New Brunswick
- Dr. Michael Brody, 228 Livingston Ave.
- Dr. Joseph H. Kler, 151 Livingston Ave.

North Hackensack
- Dr. Cornelius J. Kraissl, 230 Kinderkamack Road

Ocean City
- Dr. F. B. Lane Haines, 15 W. Maple Shade Ave., Beesleys Point

Park Ridge
- Dr. Harold H. Vandersluis, 40 Pascack Road

Passaic
- Dr. Morris H. Saffron, 292 Paulison Ave.

Plainfield
- Dr. John K. Nevius, Jr., 1165 Park Ave.

Red Bank
- Dr. Frank J. Goff, 62 Maple Ave.

Roseland
- Dr. Alfred R. Dardis, 7 Evergreen Place

Rutherford
- Dr. Leon J. Schwartz, 162 Chestnut St.

Somerville
- Dr. Robert V. Anderson, 315 E. Main St.

Trenton
- Dr. Swithin Chandler, Jr., 2556 S. Broad St.
- Dr. William E. Mountford, 217 N. Warren St.
- Dr. Horace M. Shaffer, 208 W. State St.

Union City
- Dr. Sol Pollack, 1906 Hudson Blvd.

Upper Montclair
- Dr. Arthur G. Hill, 76 Bellevue Ave.

Vineland
- Dr. Pasquale A. Ruggieri, 803 Elmer St.

Weehawken
- Dr. Frank A. Marshall, 2202 Palisade Ave.

Woodbury
- Dr. Ralph L. Moore, 509 N. Broad St.

New New Jersey ACCP Fellows

The American College of Chest Physicians announces the re-election of Dr. A. Albert Carabelli of Trenton as Governor of that College for New Jersey, and the awarding of Fellowship certificates to the following:

Charles D. Driscoll, West Collingswood
Max Finkelstein, Jersey City
Newton H. Gresser, Hackensack
Lucian G. Massarelli, Teaneck
Charles E. Meidt, Haddonfield

Obituaries • • •

DR. LOUIS DAVIS

A coronary attack took the life of Dr. Louis Davis on June 27. Born in Newark in 1896, he was graduated from Long Island College of Medicine in 1919. After interning at St. Michael's in Newark, he entered private practice in Newark and served the people of that area from 1921 until 1960. He became increasingly interested in surgery and at the time of his death, Dr. Davis was a senior attending surgeon at St. Michael's. He also did some industrial medicine and served as medical director of the Newark office of the Westinghouse Corporation. He was an FACS and was active in many positions in the staff organization of St. Michael's Hospital.

DR. ANNUNCIATO LAFACE

New Jersey's medical community was shocked on June 6 by the tragic and untimely death of Dr. Annunciato LaFace. Born in Italy in 1925, Dr. LaFace earned his M.D. at the University of Rome in 1951 and interned in that city until 1953 when he came to the United States for a supplementary internship at the St. Mary's Hospital in Hoboken. On concluding this service, he was accepted for an anesthesiology residency at the Jersey City Medical Center. After successful completion of this three-year residency, Dr. LaFace moved to Elizabeth, joining our Union County Medical Society. He became affiliated with the anesthesiology department at two Elizabeth hospitals, and was serving in this work at the time of his death.

DR. JAMES H. LOWREY

Essex County lost one of its pioneer surgeons on July 9 with the death that day of James H. Lowrey of Maplewood, a past-president of the Essex County Medical Society. Dr. Lowrey received his M.D. degree at Columbia University in 1902 and interned at the Martland Medical Center, then known as the Newark City Hospital. From 1903 to 1956 he practiced in the Ironbound section of Newark, where he was, for more than a half-century a popular, respected and beloved figure. He was affiliated with many hospitals in Newark and was chief or president of the staff of several of them. In 1908 he served in the New Jersey General Assembly. He also had a term as president of the Anatomic and Pathologic Society. He had active duty in the Army's Medical Corps in World War I. Dr. Lowrey was 80 years old at the time of his death.

DR. JAMES A. McCARRON

Dr. James A. McCarron died of a heart attack on July 31 at the early age of 52. Born in New York in 1907, his family brought him to Bayonne in 1913. In 1934 he received his M.D. degree at the University of St. Louis and interned at St. Mary's Hospital in Hoboken. He first did general practice, but then became increasingly interested in surgery, and became a Fellow of the American College of Surgeons. He was on the surgical staff of Bayonne Hospital, and was active in our Hudson County Medical Society.

DR. PETER A. PETRONE

At the untimely age of 43, Dr. Peter Petrone died of a coronary attack on July 19. Dr. Petrone had received his M.D. from Hahnemann in 1943, and then served in Europe in the Army Medical Corps. He was a general practitioner affiliated with both the Martland Medical Center and the Newark Presbyterian Hospital. Dr. Petrone was a native and life-long resident of Newark.

DR. BENNO B. TUNIS

Born in Vienna, Austria in 1889, Dr. Benno B. Tunis died in Orange, N. J., on July 23. An obstetrician, Dr. Tunis was author of the book *Gestation and Heart Disease*. He was a diplomate in Obstetrics and Gynecology. He earned his M.D. at the University of Vienna in 1920, and after internship and residency in gynecology in Austria, he came to New Jersey in 1941, becoming affiliated with the Beth Israel Hospital in Newark. Dr. Tunis was a member of the Essex County Medical Society and was active in the American Maternal Welfare Society.

Announcements • • •

Civil and Aerospace Medical Seminar

The date of the Seminar sponsored by the Flying Physicians' Association of New Jersey to be held at the National Aviation Facilities Experimental Center in Atlantic City, has been changed to Saturday, October 1. There will be an open house from 9 to 5, presenting the work of the NAFEC on aeronautical communications and navigation. Tours of the Center's facilities will be conducted during the day. Lectures are scheduled from 1:30 to 3 p.m.

Registration desk will be located in the Operations Building. Luncheon facilities are available and there will be a clam-bake at 4 p.m. Guests are invited to bring their families as well as another interested physician.

Physicians who plan to attend are requested to write or phone Dr. James L. Garofalo, 107 Smull Ave., Caldwell; or Dr. Louis Raymond, 719 Park Ave., East Orange.

Rhinologic Society Meets

Chicago is the site of the next meeting of the American Rhinologic Society on October 8, 1960. Speakers include Morris Fishbein and H. L. Williams of Mayo Clinic. There will be seminars on nasal pressure tests, implant materials, and hormones in rhinology. For more details, write to Dr. Robert Hansen, 1735 North Wheeler Avenue, Portland 17, Oregon.

Chest Disease Course in New York

Recent advances in Diseases of the Heart and Lungs is the title of a new course to be given during the 5-day period starting November 14, 1960. The lectures and demonstrations (by a star-studded faculty) will be at the Park Sheraton Hotel in New York. Tuition (including 5 luncheons) is $100. For more details, write to American College of Chest Physicians at 112 East Chestnut Street, Chicago (11).

Institute on Nutrition and Metabolism

On October 29, 1960, the Philadelphia County Medical Society and the American College of Gastroenterology will jointly offer a series of panels on problems in metabolism and nutrition. A galaxy of distinguished specialists in various aspects of metabolism and nutrition has been recruited to moderate the colloquia or deliver talks at the session which will be at the Bellevue Stratford in Philadelphia. The Institute is approved for 4 hours of Category II credit, AAGP. For details, write to Dr. Michael G. Wohl, County Medical Society, 1727 Pine Street, Philadelphia 3, Penna.

Medical Cruise to Virgin Islands

An intensive graduate course in medicine, surgery and pediatrics is announced for the period November 9 through November 18 on the Swedish cruise ship *Kungsholm*. The ship sails from New York and stops at Puerto Rico as well as Charlotte Amalie. The instructional program provides 20 hours AAGP credit. The curriculum includes clinico-pathologic conferences, lectures and demonstrations. This is under the aegis of Duke University Medical School and inquiries should be directed to Dr. W. M. Nicholson, Assistant Dean, Duke University, Box 3017, Durham, North Carolina.

Are You a Civil War Descendant?

At next year's Civil War centennial, a roster of physicians who are descendants of Civil War veterans will be presented. The list is being compiled by Dr. Karl Rothschild of 747 West Seventh Street, Plainfield. If you —or your spouse—is a descendant of a Civil War veteran (either Union or Confederate Army or Navy) please send your name and the name of the ancestor to Dr. Rothschild.

Seminar on Kidney Disease

The College of American Pathologists will hold a meeting at the John Marshall Hotel in Richmond, Virginia, on November 25 and 26, 1960. Speakers will include Drs. S. M. Kurtz, P. P. Ladewig, H. D. McIntosh, C. L. Pirani, David E. Smith, and Max Wachstein. The slide seminar will be conducted by Drs. Paul Kimmelstiel and Solomon Papper. The dinner speaker will be Dr. Frank C. Coleman, president of the College of American Pathologists.

Slide sets for this seminar may be purchased at $15 per set by writing to: Dr. G. T. Mann, P. O. Box 41, Medical College of Virginia, Richmond 19, Virginia.

New Serology Report Form

The N. J. State Department of Health announces that the old yellow-colored serology report form has just been replaced by a new form, known at SER-1. This is issued in duplicate. It will identify specimens sent to the Division of Laboratories for testing and convey tests results back to the physician.

Supplies of the new form are distributed with tubes ordered from the Division of Laboratories; or will be mailed to any physician or institutions requesting them.

Center for Study of Lower G.I. Carcinoma

The cooperation of New Jersey physicians is requested in studies on colon and rectal carcinoma at the National Institutes of Health, Bethesda, Maryland. Encouraging results in the treatment of gastrointestinal carcinoma have been reported using the pyrimidine analogues 5-fluorouracil and 5-fluorodeoxyuridine.

The National Cancer Institute is conducting studies of these agents in carcinoma of the colon and rectum. The side effects of these drugs may be considerable so patients must be in good general condition to tolerate adequate doses. Also the presence of tumor masses which can be either measured directly or demonstrated on roentgen films is necessary to determine the antitumor effect of the drugs in short periods.

Patients can be accepted for these studies if they are ambulatory, have normal leukocyte count, renal and hepatic function and if they have metastases in the lung, peripheral lymph nodes or skin.

Physicians who wish to have their patients considered for study at the National Cancer Institute may write or call:

> Dr. Clyde O. Brindley or Dr. Paul P. Carbone, National Cancer Institute, Bethesda 14, Maryland (OLiver 6-4000, Ext. 4251)

Your Books and Journals Can Be Useful

Your outmoded medical books and medical journals will be appreciated by knowledge-hungry physicians and hospitals in less fortunate parts of the world. If you have any such publications, write to Dr. Louis H. Bauer, Secretary, World Medical Association, 10 Columbus Circle, New York 19, N. Y. Tell Dr. Bauer what you have (give years of publication for each item) and he'll tell you what can be done.

Here is another—and unique—service provided by the World Medical Association. Dr. Bauer writes:

> "We are willing to act as the clearing house or matching centre between the doctor who has a periodical or book with which he has finished and the doctor who wishes to receive this periodical or book, but either because of currency regulations or the actual cost involved, is denied access to it. The medical associations in the Pacific and Asian areas are providing us with the names and addresses of doctors who appreciate receiving current medical literature. We have information as to the fields of interest or specialties of these doctors.
>
> "You supply us with the names of the periodicals you would be willing to dispense in single copies at regular intervals. In exchange for your list, you will receive an initial supply of wrappers addressed to the foreign doctor who desires to share your periodicals. You (or your secretary) prepares the periodical for mailing as you find you have no further use for its contents, and 'presto'—the program is underway.
>
> "Of course we don't guarantee you won't begin to receive letters bearing fascinating stamps from far-away places filled with gratitude for your thoughtfulness in sharing your wealth of medical science!"
>
> —Louis H. Bauer, M.D.

County Society Reports • • •

Middlesex

The annual dinner meeting, with installation of officers for 1960-1961 of the *Middlesex County Medical Society* was held at the Pines, Metuchen, at 6:30 p.m. on June 22.

On recommendation of the Judicial Medical Ethics Committee, Dr. B. F. Slobodien, chairman, the following applications were approved for presentation to the Committee on Credentials of The Medical Society of New Jersey for election: To Regular membership from two years of Associate membership—Dr. Salvatore Berculo of Perth Amboy; to two years of Associate membership—Drs. John N. Kennedy, George L. Wolcott of New Brunswick and Daniel Schoicket of East Brunswick.

The following were elected and installed: *President*—Dr. Stanley A. Gadek, Perth Amboy; *Vice-President*—Dr. Thomas McLaughlin, Metuchen; *Secretary*—Dr. Donald T. Akey, Metuchen; *Treasurer*—Dr. Reubin Levinson, Perth Amboy and *Reporter*—Dr. Thomas I. Steinberg, Metuchen. *Board of Trustees* for one year—Dr. John A. Smith, *Chairman;* Drs. C. H. Calvin, Malcolm M. Dunham, Charles Gandek, George T. Henderson, George J. Kohut, A. Marshall Smith, Sr., Joseph F. Sandella and B. F. Slobodien; *Judicial-Medical Ethics Committee*—Drs. B. F. Slobodien, Chairman, R. E. Siegel and E. J. Tyrrell, one year; and S. David Miller and William E. Sherman, two years; *Delegates and Alternates* for three years: Drs. Donald T. Akey; Alternate—R. J. Powers; R. G. Matflerd; Alternate—Martha F. Leonard; John H. Rowland; Alternate—S. David Miller; Jack E. Shangold; Alternate—Albert A. Schwartz; Thomas F. McLaughlin; Alternate—William Rubin; E. J. Tyrrell; Alternate—G. R. Hardy; John S. Van Mater; Alternate—Joseph C. Vargyas; Replacements for term expiring in 1962: Drs. A. J. Barbano replacing A. Shayevitz as Delegate; E. J. Brezinski replaced by Edward Jasionowski as Alternate; and G. Aitken to replace A. J. Barbano as Alternate; Delegate and Alternate to The Medical Society of New Jersey Nominating Committee for 1961—Charles H. Calvin and Gerard R. Gessner.

A convivial evening of entertainment and dancing by the members and wives wound up the year's activities.

THOMAS I. STEINBERG, M.D.

Reporter

Book Reviews • • •

Many of the reviews in this section are prepared in cooperation with the Academy of Medicine of New Jersey.

Virus Virulence and Pathogenicity. Ciba Foundation Study Group No. 4. Little, Brown & Co., Boston, Mass, 1960. Pp. 114. ($2.50)

This is essentially a report of a Study Group which met in honor of Professor Mulder, the participants being largely of British origin. The talks centered about the evidence for and against variation in virulence and human pathogenicity and a discussion of the rationale, if any, of obtaining appropriate strains of virus for live virus vaccination.

The presentation dealt specifically with attempts to define and measure virus virulence, the influence of host cell factors, the effect of virulence on changes in parasites in host, the broad aspects of human virulence in influenza viruses, the severity of influenza as a reciprocal of host susceptibility and the virulence for man of some respiratory viruses passed in tissue cultures.

The reader is introduced to virus terminology, as well as such terms as "cytopathogenic effect" and "enteric cytopathogenic human orphan viruses," commonly referred to in the literature as ECHO viruses.

The reviewer was impressed with the inability of the workers to come to an exact definition of what constituted virus virulence. The question of virulence is closely tied up with the virus adaptation of different species. The participants noted the possible hypothesis about virulence, namely, that symptoms or pathologic lesions occur when a certain crucial virus concentration is reached.

The Conference acknowledged the role of bacteriologists, like Sir Alexander Fleming, who gave

the world antibiotics, as a greater factor in limiting the 1957 epidemic of influenza than the work of the virologist.

A 3½ page index completes the 114 page volume, which will constitute thought-provoking reading for those interested in virus mechanisms of human disease processes.

THOMAS K. RATHMELL, M.D.

De Magnete. William Gilbert, M.D. Translated from the Latin by P. F. Mottelay. New York, 1960. Dover Publications. Pp. 368 with 90 figures. Paperbound. ($2.00)

Dr. William Gilbert was the physician to Queen Elizabeth I. He lived from 1540 to 1603 and was one of the most distinguished scientists of his age. This book, a pioneer treatise on magnetism, was written in 1600 and translated into idiomatic English by P. F. Mottelay in 1890. The present Dover edition makes it available for the first time at a popular price. Dr. Gilbert uses the modern experimental scientific method to study magnetism. All aspects of magnetism are thoroughly studied, both deductively and experimentally and cobwebs of superstition are cleaned out. Books like this are part of our medical and scientific heritage and it is too bad more of us don't read them.

HERBERT BOEHM, M.D.

Arthritis: Medical Treatment and Home Care. By John H. Bland, M.D. New York, 1960, Macmillan. Pp. 208, with illustrations. ($4.95)

This is offered as a book for family use. Dr. Bland meets this need admirably, though it may be a bit more than the average patient can digest. On the other hand, it has great interest and information to any practitioner of medicine. Much of the book is devoted to the history of rheumatology and the origin of the terminology. Dr. Bland takes great pains to differentiate between rheumatoid arthritis and degenerative joint disease (osteoarthritis). Regarding therapy, Dr. Bland goes into great detail describing exercises and local measures that the patient and family can do at home. He offers a complete listing of all available arthritis clinics.

The text is well printed and has many fine old prints and caricatures, which makes for interesting reading.

Dr. Bland is to be congratulated for this timely monograph on diseases of the joints. His optimism about future results from research can help the arthritic sufferer face the future with renewed hope.

HERMAN H. TILLIS, M.D.

The Triumph of Surgery. By Jurgen Thorwald. New York, 1960. Pantheon Books. Pp. 454, illustrated. ($6.50)

This well written book, capably translated from the German original, takes up the history of surgery where the author's previous volume "The Century of the Surgeon" left off. It allows the reader to witness vicariously surgery's greatest triumphs. Through its pages one can follow surgical history in the making by its brilliant and courageous pioneers.

In his earlier book, Jürgen Thorwald told the story of surgeons in the latter half of the nineteenth century who, as a result of discoveries in anesthesia, antisepsis and asepsis, made surgery a science. Now the fictitious Dr. Hartman again gives us an on-the-spot account of great moments in surgical progress during the past eighty years. He begins at the Third International Medical Congress at London in 1881—at a time when new horizons were opening in operative technic. Technical achievements from that time have brought marvels in surgery of the nervous system, thoracic, abdominal and pelvic viscera.

Dr. Hartman tells of great medical figures from many nations during this era: Theodore Kocher—Swiss pioneer of modern goiter surgery; William Macewen—Scottish neurosurgeon; Marion Sims—American gynecologist; Morell Mackenzie—British otolaryngologist who attended the ailing German Emperor Frederick III; Jean Martin Charcot—eminent French neurologist; Sigmund Freud—early experimentor with local anesthesia; The Mayo brothers, John B. Murphy, William Halsted, William Welch—and numerous others.

"The Triumph of Surgery" provides a thrilling eyewitness narrative of the evolution of modern surgery. The book is nicely illustrated and has an index. One must read this interesting story to fully appreciate its content and style.

FRED B. ROGERS, M.D.

Textbook of Otolaryngology. By D. D. DeWeese, M.D. and W. H. Saunders, M.D. St. Louis, 1960. Mosby. Pp. 464. ($8.75)

Written in simple, concise language, this book is lavishly illustrated. Topics are logically arranged. Easy reference is helped by a good table of contents and a well selected index. Format of the book shows good taste and care in preparation, and subject matter open to question is rare.

The volume is easy to read and interestingly written. A medical student or general practitioner with curiosity could go through it carefully in the spare time of a week and have a workable knowledge of the common diseases of the ear, nose, and throat.

Instruments required for treatment are well illustrated. There is logical, conservative philosophy

of management. Conditions requiring the care of a specialist are pointed out and the procedures are outlined that he would probably use.

The section on the ear is particularly good. It explains clearly the anatomy and physiology of the vestibular and cochlear divisions of the eighth nerve. Tests of hearing and function of the labyrinth are described and interpreted. There is a short and understandable presentation of the newer operations for repair of the drum and for stapes mobilization and fenestration in otosclerosis. The indications for operation and the technic and results are discussed.

There is an interesting chapter on speech therapy. The bibliography at the end of each section makes it easy for the reader to study further.

WRIGHT MACMILLAN, M.D.

From Magic to Science. Charles Singer, M.D. New York, 1960 Dover Publications. Pp. 253. Paperbound. ($2.00)

In this profusely illustrated but modestly priced book, Dr. Singer describes the astonishing Roman hospital system and medical and scientific lore of the middle ages. He tells how European science was reawakened through Arabic and Jewish scholarship. The text consists of seven essays—Roman science; the Dark Ages; the Lorica of Gildas; early British medicine; early Herbals; the Vision of Hildegard; and the legends of the school of Salerno. Dr. Singer describes in vivid language. But he does more than describe. He comments and connects and gives a sense of movement and continuity to the trend from magic to science. It is a scholar's book comprehensible to any intelligent reader.

ABRAHAM LEFF, M.D.

From Fish to Philosopher. Homer W. Smith. Boston, 1959. Little Brown. Pp. 304. Price Not Stated.

The medium in which we live is not air. It is the liquid that bathes all our tissues. The composition of this fluid is determined not by what the body takes in but by what the kidneys keep in. Thus, as Dr. Smith sees it, evolution is the story of how our kidneys work. As we mount the evolutionary tree, the structure of the kidney changes to cope with the new environment. The evolution of the kidney is thus traced, with many enchanting side trips into animal and human physiology, and a final chapter on dropsy and diuresis. This book will make any urologist proud of his specialty, and will deepen any reader's reflections on the glory of the human being.

HENRY A. DAVIDSON, M.D.

Your Heart: A Handbook for Laymen. H. M. Marvin, M.D. Garden City, N. Y., 1960. Doubleday. Pp. 335. ($4.50)

Dr. H. M. Marvin, past president of The American Heart Association, should be congratulated for this excellent book, directed to the intelligent lay public.

The comprehensive text deals with a consideration of the heart's structure and function, and the rudiments of the circulation. In order, Dr. Marvin considers the arrhythmias, rheumatic and hypertensive disease, congestive failure, anginal syndrome and coronary occlusion. An excellent discussion of the causes of coronary occlusion and of the role of cholesterol and anticoagulants is included. Other chapters deal with heart disease in pregnancy, the effects of obesity, tobacco, and the use of the roentgenogram and electrocardiogram in the diagnosis of heart disease.

Interspersed throughout the text are numerous quotations from literary sources, often pithy, always appropriate. On controversial matters, the author presents conflicting views without taking sides.

The book will be of use to college-educated laymen interested in an authoritative, short and not-too technical discussion of the basic organs of the body.

MAURICE J. ZIMMERMAN, M.D.

Health Physics Instrumentation. By John S. Handloser, New York, 1960. Pergamon Press. Pp. 182. ($6.50)

With the increasing use of radioactive isotopes in medicine, biology and industry methods have been developed to keep radiation exposure within safe limits. This field of protection against radiation hazards is the domain of the health physicists. The book here reviewed lists the instruments used by the health physicists in the control and measurement of these hazards. It is of special value to beginners in the use of radioactive isotopes. It contains descriptions of commonly used instruments and their calibration and limits of usefulness. Radiation detectors and monitors are described in considerable detail.

The presently accepted limits of radiation exposure are reviewed. There is also a good chapter on radiation physics. Problems in radiation dosimetry are discussed in considerable detail.

Graphs, charts and photographs illustrate the subject matter and there is an excellent bibliography at the end of each chapter. This book is one of a series of monographs which are being published on nuclear energy and is an authoritative review for the well prepared beginner as well as a source book for the experienced worker.

LOUIS J. LEVINSON, M.D., F.A.C.R.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

SEPTEMBER, 1960 • VOL. XXXIII, NO. 7

THE MANAGEMENT OF RELAPSE IN TUBERCULOSIS

Tuberculosis patients who have had chemotherapy in the past are more difficult to treat if relapse occurs than those who were treated without drugs. Drugs combined with modified bed rest should be used in all cases. Effective first-treatment is the best defense against relapse.

The management of patients who relapse after treatment for tuberculosis can be divided into two groups, one of which is relatively easy, the other often very difficult. The easy group is composed of patients who were treated, apparently successfully, without antituberculosis drugs. Every year a small number of these are found to have active disease. They should be handled exactly as first-treatment cases: with adequate rest, two drugs, and—if indicated—surgery. If the patient is a responsible graduate of an old-time tuberculosis hospital, it may not be necessary to keep him in a hospital for the entire duration of drug therapy. A preliminary hospital work-up is needed for complete evaluation. This should include radiologic and bronchoscopic study, pulmonary function tests, bacterial drug susceptibility determinations, and careful observation for untoward drug reactions. After this, if the home is adequate and if the patient is sufficiently intelligent and reliable, he can be treated on an outpatient basis. This does *not* mean that he can continue to work. To give a patient a bottle of pills and tell him to come back in 4 or 6 months, is not tuberculosis treatment.

Patients with much fibrosis or those who have had pneumothorax or thoracoplasty may have greatly reduced pulmonary function. Surgical measures should be undertaken only after careful assessment of pulmonary function. Older patients who improve and turn negative on chemotherapy should be maintained on drugs for a long, long time. The more extensive the original lesion or the older the patient, the longer the drug regimen. Drugs can be taken "For Life" in the treatment of tuberculosis, just as in the treatment of diabetes, pernicious anemia, epilepsy, and other diseases.

ROBERT V. COHEN, M.D., *Philadelphia Medicine, January 15, 1960.*

RELAPSE AFTER CHEMOTHERAPY

By far the larger and more difficult group of patients seen in relapse today are those who have had chemotherapy in the past. The great majority of these unfortunate situations arise because someone has broken one of the three fundamental commandments of chemotherapy:

I. Thou shalt not stop first-treatment drugs too soon.

II. Thou shalt not interrupt treatment.

III. Thou shalt not use up thy best drugs in the first round.

A patient who has active tuberculosis after "adequate" drug treatment is in a very tough spot indeed.

The initial work-up should include, in addition to the items mentioned above, a meticulous history of drug treatment, dosage, and duration. Tests of bacterial susceptibility to drugs are mandatory. By and large, test-tube resistance to streptomycin parallels clinical resistance. Giving more streptomycin in such situations can cause toxic reactions but do no good. In first-treatment cases, resistance to isoniazid in the test tube does not

always parallel the clinical situation; if the drug is continued, clinical improvement may be anticipated. This does not apply to patients who relapse while on treatment or after treatment. These patients usually show both test-tube and clinical resistance. If the patient in relapse has not had one of the major drugs (isoniazid or streptomycin), he certainly should get it, in combination with PAS or a PAS substitute. Usually, unfortunately, the patient has had isoniazid-PAS-streptomycin prior to relapse. One reason why many patients use up their two best drugs during first treatment is the improper evaluation and handling of drug reactions. Reactions can be classified as: (a) Toxic, such as eighth nerve damage due to streptomycin or neuropathy due to isoniazid. (b) Intolerance, gastro-intestinal symptoms due to PAS. (c) Hypersensitivity, or true allergy: fever, adenitis, rashes, changes in blood, purpura, hepatitis, shock, even death.

DRUG REACTIONS

Every drug reaction should be analyzed and classified, as each type requires different handling.

Toxic reactions: reduce dose, change form, give antidote if available (B6 for isoniazid).

Intolerance: reduce dose, change form (KPAS or resins for sodium PAS), give counteracting medicine (antacids, etc.).

Hypersensitivity: STOP DRUG. Desensitize. If the patient has used up his first team drugs, the second and third team drugs are left. These, alas, are not too good. Pyrazinamide is a potent drug. It is best when given in combination with isoniazid, which is already used up. It is potentially toxic to the liver (3.5 to 10 per cent in various studies), hence most physicians prefer to give it for a relatively short time—about three months, with frequent tests of liver function. If any surgery is planned, pyrazinamide is an excellent drug to "cover" the period of surgery and convalescence.

Cycloserine is not a very potent drug; used alone to treat a patient in drug-resistant relapse, it is of little value. Viomycin and terramycin have some effect, but are not very potent. Kanamycin has proved more toxic than useful. Hinconstarch, streptovaricin, and the hydrazones of isoniazid all seem to work better in reports from abroad than in patients in relapse.

Corticosteroid drugs, which can be very helpful in some selected, very sick, first treatment cases, are dangerous and should be avoided in relapse patients. If these agents are used without an effective "umbrella" of antituberculosis drugs, they can cause serious spread of the tuberculosis.

We must not forget the value of old-fashioned bed rest. This unspectacular modality has helped untold thousands of patients in the past hundred years; in many cases it was the only treatment used. Bed rest, not all day but 18 to 20 hours a day, can reduce toxicity, improve resistance, and frequently allow a relapsed patient to "cool off" sufficiently, either to overcome his disease or to tolerate surgery.

Surgery does not have to be resection. There is still a place for thoracoplasty in patients with localized upper lobe cavitation, who are poor risks for resection. Plombage is a less effective, but also less drastic, procedure and may be used as a temporary expedient.

Any surgical procedure is more dangerous when performed on a patient who is excreting drug-resistant tubercle bacilli. It takes sound and mature medical judgment to decide whether to take a calculated risk or to leave a bad situation alone.

To sum up the treatment of relapse: There is no simple formula. Practically all patients should be in a hospital. A first-line drug, not used before, should be given with either PAS or a comparable drug. Isoniazid may be given, hopefully, but may do no good. Only occasionally will very high doses of isoniazid (with 10 per cent B6) prove helpful after regular doses have become ineffective. The best combination of second and third team drugs should be used. Modified bed rest is an extremely valuable treatment. Collapse or resectional surgery is more hazardous in the presence of drug resistant tubercle bacilli, but can be carried out in selected cases. The best management of relapse is to try to prevent it by carrying out effective first treatment.

NEW JERSEY TRUDEAU SOCIETY

is the medical section of

NEW JERSEY TUBERCULOSIS AND HEALTH ASSOCIATION

15 EAST KINNEY STREET, NEWARK 2, NEW JERSEY

In Acute Illness . . .

NILEVAR®

Can Speed Recovery

"Commonly, negative nitrogen balance[1] occurs during acute febrile illnesses and following traumatic events and surgical procedures." As much as 300 to 400 Gm. of nitrogen[2] may be destroyed daily in severe infections. Convalescence[1] is delayed when negative nitrogen balance is large and persistent.

NILEVAR Builds Protein, Speeds Convalescence to Complete Recovery[3-6] ". . . we were impressed[3] with the efficacy of Nilevar as an anabolic agent. All of the patients reported feeling much more vigorous and experiencing an increase in appetite. . . ."

The actions of Nilevar[4] in reversing a negative nitrogen balance—and therefore a negative protein balance—improving the appetite and increasing the sense of well-being can be expected to shorten the illness and the convalescence of these patients.

An initial daily dosage of 30 mg. of Nilevar (brand of norethandrolone) is suggested. After one to two weeks, this dosage may be reduced to 10 or 20 mg. daily in accordance with the response of the patient. Continuous courses of therapy should not exceed three months, but may be repeated after rest periods of one month. Nilevar is supplied as tablets of 10 mg., drops of 0.25 mg. per drop and ampuls of 25 mg. in 1 cc. of sesame oil with benzyl alcohol.

1. Eisen, H. N., and Tobachnick, M.: Protein Metabolism, M. Clin. North America 39:863 (May) 1955. 2. Jamison, R. M.: General Nutritive Deficiency, Virginia M. Month. 83:67 (Feb.) 1956. 3. Goldfarb, A. F.; Napp, E. E.; Stone, M. L.; Zuckerman, M. B., and Siman, J.: The Anabolic Effects of Norethandrolone, a 19-Nortestosterone Derivative, Obst. & Gynec. 11:454 (April) 1958. 4. Botsan, R.: Investigator's Report, Feb. 11, 1956. 5. Weston, R. E.; Isaacs, M. C.; Rosenblum, R.; Gibbons, D. M., and Grossman, J.: Metabolic Effects of an Anabolic Steroid, 17-Alpha-Ethyl-17-Hydroxy-Norandrostenone, in Human Subjects, J. Clin. Invest. 35:744 (June) 1956. 6. Brown, C. H.: The Treatment of Acute and Chronic Ulcerative Colitis, Am. Pract. & Digest Treat. 9:405 (March) 1958.

G. D. SEARLE & CO.
CHICAGO 80, ILLINOIS

Research in the Service of Medicine

for a smooth downward curve

New Rautrax-N results in prompt lowering of blood pressure.[1] Rautrax-N, a new and carefully developed antihypertensive-diuretic preparation, provides improved therapeutic action[1] plus enhanced diuretic safety for all degrees of essential hypertension. A combination of Raudixin and Naturetin, Rautrax-N facilitates the management of hypertension when rauwolfia alone proves inadequate, or when prolonged treatment, with or without associated edema, is indicated.

Naturetin, the diuretic of choice, also possesses marked antihypertensive properties, thus complementing the known antihypertensive action of Raudixin. In this way a lower dose of each component in Rautrax-N controls hypertension effectively with few side effects and greater margin of safety.[1-16]

Other advantages are a balanced electrolyte pattern[1-16] and the maintenance of a favorable urinary sodium-potassium excretion ratio.[2-16] Clinical studies[1-5] have shown that the diuretic component of Rautrax-N—Naturetin—has only a slight effect on serum potassium. The supplemental potassium chloride provides additional protection against potassium depletion which may occur during long term therapy.

Rautrax-N may be used alone or in conjunction with other antihypertensive drugs, such as ganglionic blocking agents, veratrum or hydralazine, when such regimens are needed in the occasionally difficult patient.

Supply: Rautrax-N—capsule-shaped tablets providing 50 mg. Raudixin (Squibb Rauwolfia Serpentina Whole Root) and 4 mg. Naturetin (Squibb Benzydroflumethiazide), with 400 mg. potassium chloride.

Dosage: Initially-1 to 4 tablets daily after meals. Maintenance-1 or 2 tablets daily after meals; maintenance dosage may range from 1 to 4 tablets daily. For complete instructions and precautions see package insert. Literature available on request.

References: 1. Reports to the Squibb Institute, 1960. 2. David, N. A.; Porter, G. A., and Gray, R. H.: Monographs on Therapy 5:60 (Feb.) 1960. 3. Stenberg, E. S., Jr.; Benedetti, A., and Forsham, P. H.: Op. cit. 5:46 (Feb.) 1960. 4. Fuchs, M.; Moyer, J. H., and Newman, B. E.: Op. cit. 5:55 (Feb.) 1960. 5. Marriott, H. J. L., and Schamroth, L.: Op. cit. 5:14 (Feb.) 1960. 6. Ira, G. H., Jr.; Shaw, D. M., and Bogdonoff, M. D.: North Carolina M. J. 21:19 (Jan.) 1960. 7. Cohen, B. M.: M. Times, to be published. 8. Breneman, G. M. and Keyes, J. W.: Henry Ford Hosp. M. Bull. 7:281 (Dec.) 1959. 9. Forsham, P. H.: Squibb Clin. Res. Notes 2:5 (Dec.) 1959. 10. Larson, E.: Op. cit. 2:10 (Dec.) 1959. 11. Kirkendall, W. M.: Op. cit. 2:11 (Dec.) 1959. 12. Yu, P. N.: Op. cit. 2:12 (Dec.) 1959. 13. Weiss, S.; Weiss, J., and Weiss, B.: Op. cit. 2:13 (Dec.) 1959. 14. Moser, M.: Op. cit. 2:13 (Dec.) 1959. 15. Kahn, A., and Grenblatt, I. J.: Op. cit. 2:15 (Dec.) 1959. 16. Grollman, A.: Monographs on Therapy 5:1 (Feb.) 1960.

Squibb Quality—the Priceless Ingredient

SQUIBB

"RAUDIXIN" ® "RAUTRAX" ® AND "NATURETIN" ARE SQUIBB TRADEMARKS.

new

The proved, effective antihypertensive—now combined with a safer, better diuretic

RAUTRAX-N*

Squibb Standardized Whole Root Rauwolfia Serpentina (Raudixin) and Benzydroflumethiazide (*Naturetin) with Potassium Chloride

no irritating crystals[1] · uniform concentration in each drop[2]

STERILE OPHTHALMIC SOLUTION

NEO-HYDELTRASOL®

PREDNISOLONE 21-PHOSPHATE-NEOMYCIN SULFATE

2,000 TIMES MORE SOLUBLE THAN PREDNISOLONE OR HYDROCORTISONE

"The solution of prednisolone has the advantage over the suspension in that no crystalline residue is left in the patient's cul-de-sac or in his lashes . . . . The other advantage is that the patient does not have to shake the drops and is therefore sure of receiving a consistent dosage in each drop."[2]

1. Lippmann, O.: Arch. Ophth. 57:339, March 1957
2. Gordon, D.M.: Am. J. Ophth. 46:740, November 1958.

supplied: 0.5% Sterile Ophthalmic Solution NEO-HYDELTRASOL (with neomycin sulfate) and 0.5% Sterile Ophthalmic Solution HYDELTRASOL®. In 5 cc. and 2.5 cc. dropper vials. Also available as 0.25% Ophthalmic Ointment NEO-HYDELTRASOL (with neomycin sulfate) and 0.25% Ophthalmic Ointment HYDELTRASOL. In 3.5 Gm. tubes.

HYDELTRASOL and NEO-HYDELTRASOL are trademarks of Merck & Co., Inc.

MSD MERCK SHARP & DOHME Division of Merck & Co., Inc., Philadelphia 1, Pa.

Use of pHisoHex for washing the skin augments any other therapy for acne — brings better results. Now, pHisoAc Cream, a new acne remedy for topical application, suppresses and masks lesions — dries, peels and degerms the skin. Together, pHisoHex and pHisoAc provide **basic** complementary topical therapy for acne.

pHisoHex, antibacterial detergent with 3 per cent hexachlorophene, removes soil and oil better than soap — provides **continuous** degerming action when used often. pHisoHex is nonalkaline, nonirritating and hypoallergenic.

When pHisoAc Cream is used with pHisoHex washings, it unplugs follicles, helps prevent development of comedones, pustules and scarring. New pHisoAc Cream is flesh-toned, not greasy. It contains colloidal sulfur 6 per cent, resorcinol 1.5 per cent, and hexachlorophene 0.3 per cent in a specially prepared base. pHisoAc is pleasant to use.

A new "self-help" booklet, **Teen-aged? Have acne? Feel lonely?,** gives important **psychologic first aid** for patients with acne and describes the proper use of pHisoHex and pHisoAc. Ask your Winthrop representative for copies.

pHisoAc is available in 1½ oz. tubes and pHisoHex is available in 5 oz. plastic squeeze bottles and in bottles of 16 oz.

pHisoHex® and pHisoAc for acne

trademark

Winthrop
LABORATORIES
New York 18, N. Y.

Now...the only Nystatin combination with extra-active DECLOMYCIN®
Demethylchlortetracycline

with extra-broad spectrum benefits:— action at lower milligram intake...broad-range action...sustained peak activity... extra-day security against resurgence of primary infection or secondary invasion.

DECLOSTATIN®

Demethylchlortetracycline and Nystatin LEDERLE

CAPSULES, *150 mg. DECLOMYCIN Demethylchlortetracycline HCl and 250,000 units Nystatin.*
DOSAGE: *average adult, 1 capsule four times daily.*

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York Lederle

REPRESENTATIVE FUNERAL DIRECTORS

OF THE STATE OF NEW JERSEY

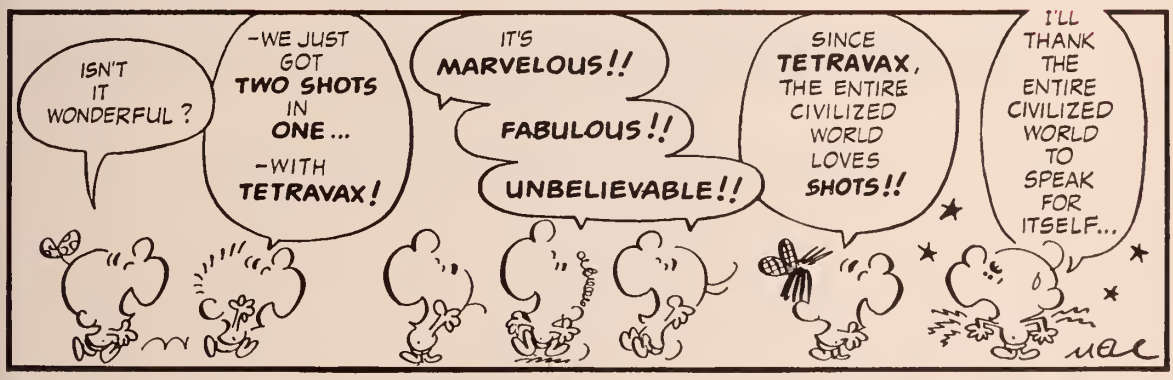
Special and Dependable Service Day and Night. Special Attention Given to Hospital Calls, Train and Express Shipments.

PLACE	NAME AND ADDRESS	TELEPHONE
ADELPHIA	C. H. T. Clayton & Son	FReehold 8-0583
ASBURY PARK	Ely Funeral Home, 514 Second Ave.	PRospect 5-0567
ASBURY PARK	Matthews, Francioni & Taylor Funeral Home, 704 7th Ave.	PRospect 5-0021
ATLANTIC CITY	H. M. Gormley Funeral Home, 911 Pacific Ave.	ATlantic City 4-3188
BERGENFIELD	Riewerts Memorial Home, 187 S. Washington Ave.	DUmont 4-0700
BLOOMFIELD	The Howard W. Kopf Funeral Home, 401 Franklin St.	PIlgrim 3-1396
BLOOMFIELD	George Van Tassel's Community Funeral Home	PIlgrim 3-1234
BOONTON	Lewis & Carey Incorporated, 312 W. Main St.	DEerfield 4-0842
CAMDEN	F. T. Walker & E. E. Walker Fun. Home, 743 Chestnut St.	WOodlawn 3-2581
CHATHAM	Wm. A. Bradley Funeral Home, 345 Main St.	MErcury 5-2428
COLLINGSWOOD	Schaffhauser Funeral Home, 983 Haddon Ave.	ULysses 4-5454
CRANBURY	A. S. Cole Son & Co., Main St.	EXport 5-0770
ELIZABETH	Aug. F. Schmidt & Son, 139 Westfield Ave.	ELIzabeth 2-2268
ENGLEWOOD	Greenleaf Funeral Home, Inc., 108 W. Palisade Ave.	ENglewood 3-0416
FREEHOLD	Van Sant Funeral Home, 73 South St.	FReehold 8-0693
HOBOKEN	Failla Memorial Home, 533 Willow Ave.	HOboken 3-0082
JERSEY CITY	Patrick J. Conte Funeral Home, 36 Tuers Ave.	HE 5-6451, DE 3-9259
JERSEY CITY	McLaughlin Funeral Home, 591 Jersey Ave.	OLdfield 3-2266
JERSEY CITY	Donald F. Wood Funeral Residence, 582 Bergen Ave.	DElaware 3-6480
LINDEN	Don McCracken Funeral Home, 2124 St. Georges Ave., E.	ELizabeth 2-3270
LITTLE FALLS	Norman A. Parker Funeral Home, 47 Main St.	CLifford 6-4700
METUCHEN	Runyon Mortuary, 568 Middlesex Ave.	LIberty 8-0149
MOORESTOWN	Harvey H. Brown Funeral Home, 10. W. Main St.	BElmont 5-5555
MORRISTOWN	Raymond A. Lanterman & Son, 126 South St.	JEfferson 9-2880
NEWARK	Barrish Funeral Home, 684 Clinton Ave.	ESsex 3-1551—9179
NEWARK	Beckett's Funeral Home, 120 W. Market St.	MItchell 2-4068
NEWARK	James E. Churchman Service, 132 Clinton Ave.	BIgelow 8-1672
NEWARK	Peoples Burial Co., 84 Broad St.	HUmboldt 2-0707
NEWFOUNDLAND	Stickle Funeral Home, Union Valley Road	OXbow 7-8141
PARAMUS	Vander Plaat Memorial Home, S-113 Fairview Ave.	DIamond 2-3688
PATERSON	R. Charles D. Legg & Sons, 384 Broadway	SHerwood 2-2385
PATERSON	Moore's Home for Funerals, 384 Totowa Ave.	ARmory 8-1500
PATERSON	Scanlan Funeral Homes, 421 Twelfth Ave. at E. 28th St.	SHerwood 2-6433
PATERSON	Vermeulen Memorial Funeral Home, 131 Haledon Ave.	MUlberry 4-3974
POINT PLEASANT	George W. Whateley Funeral Home, 1105 Arnold Ave.	TWinbrook 9-0792
RAHWAY	Lehrer Funeral Home, 275 W. Milton Ave.	FUlton 8-1874
RAMSEY	The Harold Van Emburgh Funeral Home, Inc.	DAvis 7-0030
RIDGEWOOD	C. C. Van Emburgh, Inc., 306 E. Ridgewood Ave.	GIlbert 5-0344
RIVERDALE	George E. Richards, Newark Turnpike	TEmple 5-0164
SOUTH AMBOY	The Gundrum Service, 237 Bordentown Ave.	PArkway 1-0241
SOUTH RIVER	Rezem Funeral Home, 190 Main St.	SOuth RIver 6-1191
SPOTSWOOD	Hulse Funeral Home, 455 Main St.	SOuth RIver 6-3041
TRENTON	Daniel Brenna Funeral Home, 340 Hamilton Ave.	EXport 3-2857
TRENTON	Ivins & Taylor, Inc., 77 Prospect St.	EXport 4-5186
TRENTON	Poulson & Van Hise, 408 Bellevue Ave.	EXPORT 6-8168
TRENTON	Saul Funeral Homes	JUniper 7-8221 and JUniper 7-0170
WEST ENGLEWOOD	Clifford H. Peinecke Funeral Home, 1312 Teaneck Rd.	TEaneck 7-2332

FOR SIMULTANEOUS IMMUNIZATION AGAINST 4 DISEASES:

Poliomyelitis-Diphtheria-Pertussis-Tetanus

PEDI-ANTICS



TETRAVAX®

DIPHTHERIA AND TETANUS TOXOIDS WITH PERTUSSIS AND POLIOMYELITIS VACCINES

now you can immunize against more *diseases...with* fewer *injections*

Dose: 1 cc.
Supplied: 9 cc. vials in *clear plastic* cartons. Package circular and material in vial can be examined without damaging carton. Expiration date is on vial for checking even if carton is discarded.

For additional information, write Professional Services, Merck Sharp & Dohme, West Point, Pa.

TETRAVAX IS A TRADEMARK OF MERCK & CO., INC.

MSD MERCK SHARP & DOHME, DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

In over five year

Proven
in more than 750 published clinical studies

Effective
for relief of anxiety and tension

Outstandingly Safe

1. simple dosage schedule produces rapid, reliable tranquilization without unpredictable excitation
2. no cumulative effects, thus no need for difficult dosage readjustments
3. does not produce ataxia, change in appetite or libido
4. does not produce depression, Parkinson-like symptoms, jaundice or agranulocytosis
5. does not impair mental efficiency or normal behavior

Miltown®
meprobamate (Wallace)

Usual dosage: One or two 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets.
Also as MEPROLABS* — 400 mg. *unmarked*, coated tablets; and as MEPROSPAN® — 400 mg. and 200 mg. *continuous release* capsules.

WALLACE LABORATORIES / *Cranbury, N. J.*

GN-2537

*TRADE-MARK

# of clinical use...

...for the tense and nervous patient

Despite the introduction in recent years of "new and different" tranquilizers, Miltown continues, quietly and steadfastly, to gain in acceptance. Meprobamate (Miltown) is prescribed by the medical profession more than any other tranquilizer in the world.

The reasons are not hard to find. Miltown is a ***known*** drug. Its few side effects have been fully reported. ***There are no surprises in store for either the patient or the physician.***

CM-2460

"Gratifying" relief from

for your patients with

'low back syndrome' and

other musculoskeletal disorders

POTENT muscle relaxation

EFFECTIVE pain relief

SAFE for prolonged use

stiffness and pain

"gratifying" *relief from stiffness and pain in 106-patient controlled study (as reported in J.A.M.A., April 30, 1960)*

"Particularly gratifying was the drug's [SOMA's] ability to relax muscular spasm, relieve pain, and restore normal movement . . . Its prompt action, ability to provide objective and subjective assistance, and freedom from undesirable effects recommend it for use as a muscle relaxant and analgesic drug of great benefit in the conservative management of the 'low back syndrome'."

Kestler, O.: Conservative Management of "Low Back Syndrome", J.A.M.A. 172: 2039 (April 30) 1960.

FASTER IMPROVEMENT—79% complete or marked improvement in 7 days (Kestler)

EASY TO USE—Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

SUPPLIED: 350 mg., white tablets, bottles of 50.
For pediatric use, 250 mg., orange capsules, bottles of 50.

Literature and samples on request.

SOMA®

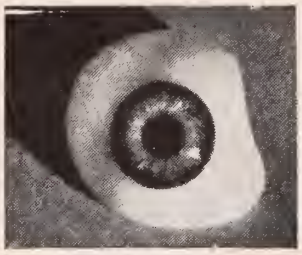
(CARISOPRODOL, WALLACE)

WALLACE LABORATORIES, CRANBURY, NEW JERSEY

Specialists in ALL TYPES of Plastic and Glass

ARTIFICIAL HUMAN EYES Exclusively Made to Order in Our Own Laboratory

Doctors Are Invited to Visit



Referred Cases Carefully Attended

AND SATISFACTION GUARANTEED

EYES ALSO FITTED FROM STOCK

PLASTIC OR GLASS SELECTIONS SENT ON MEMORANDUM UPON REQUEST

Implants and Plastic Conformers in Stock

FRIED & KOHLER, INC.

665 FIFTH AVENUE
near 53rd Street

NEW YORK CITY, N. Y.
Tel. ELdorado 5-1970

"PRESCRIBE WITH CONFIDENCE"

KATES BROS.

SCIENTIFIC SHOE FITTING

A Shoe and Last for Every Foot

SOLD ON Rx ONLY
CORRECTIVE FOOTWEAR
FOR MEN-WOMEN-CHILDREN

SOLD ON Rx ONLY
OUTFLAIR SHOES
FOR CLUB FEET

177A JEFFERSON AVE.
PASSAIC, N. J.

69 WESTWOOD AVE.
WESTWOOD, N. J.

202 MAIN ST.
HACKENSACK, N. J.

Dennis Brown Splints — in all sizes — carried in stock

taken at bedtime

BONADOXIN®

STOPS MORNING SICKNESS IN 94%

OFTEN WITH JUST ONE TABLET DAILY

by treating the symptom—nausea and vomiting—as well as a possible specific cause—pyridoxine deficiency

each tiny Bonadoxin tablet contains:
Meclizine HCl (25 mg.) for antinauseant action
Pyridoxine HCl (50 mg.) for metabolic replacement.

usual dose: One tablet at bedtime; severe cases may require another tablet on arising.

supply: Bottles of 25 and 100 tablets. Bonadoxin also effectively relieves nausea and vomiting associated with: anesthesia, radiation sickness, Meniere's syndrome, labyrinthitis, and motion sickness. Also useful in postoperative nausea and vomiting.

Bibliography on request.

For infant colic, try Bonadoxin Drops. Each cc. contains: Meclizine 8.33 mg./ Pyridoxine 16.67 mg.

Roerig Rx

New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being™

and... when your OB patient needs the best in prenatal vitamin-mineral supplementation...
OBRON®

WALKER-GORDON CERTIFIED SKIMMED MILK

Made by simply removing the cream from Certified Whole Milk, the highest-quality, cleanest Milk ever produced. Tastes delicious . . . uniform flavor the year-around . . . thus minimizing patient's normal resistance to Skimmed Milk intake. Guaranteed free of Penicillin. Write for more information.

Now in individual half-pint paper containers for hospitals, hotels, restaurants

WALKER-GORDON CERTIFIED MILK FARM

Plainsboro, N. J. • SWinburne 9-1234

New York: WAlker 5-7300 • Phila.: LOcust 7-2665

Also Certified Raw, Pasteurized, Homogenized-Vit. D, Acidophilus and Fresh Lo-Sodium Milks; available through leading Milk Dealers or call Walker-Gordon.

Dugan's

"Bakers for the Home"

New - LITE DIET BREAD

(White Bread Baked Without Shortening)

Calories per Slice 42 Calories per Oz. 70

ALSO

SALT-FREE BREAD

GLUTEN AND PROTEIN BREADS

100% WHOLE WHEAT

100% Whole Wheat Crackers

New York New Jersey

Connecticut Pennsylvania

"AT YOUR DOOR OR TO YOUR STORE, IT'S DUGAN'S FOR BETTER BAKED GOODS"

Phone for Delivery

HUmboldt 2-6007 in Newark

(or your local phone book for branch nearest you)

NOW! **DIABETICS CAN ENJOY**

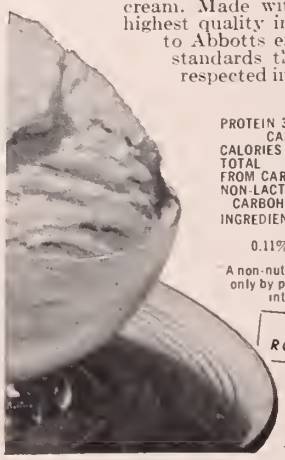
(UNDER MEDICAL ADVICE)

Abbotts

ARTIFICIALLY SWEETENED

ICE CREAM

Your patients whose sugar intake is restricted will relish the extra delicious flavor of Abbotts new, sugar-free ice cream. Made with infinite care and highest quality ingredients according to Abbotts exacting standards — standards that are most highly respected in the dairy industry.



COMPOSITION

PROTEIN 3.52% MILK FAT 10.52%

CARBOHYDRATES 21.35%

CALORIES PER OUNCE	AVOIR.	FLUID
TOTAL	55.02	33.31
FROM CARBOHYDRATES	24.21	14.66
NON-LACTOSE CARBOHYDRATES	18.03	10.92

INGREDIENTS: CREAM, MILK, SORBITOL, STABILIZER AND 0.11% CYCLAMATE CALCIUM*

*A non-nutritive artificial sweetener for use only by persons who must restrict their intake of ordinary sweets.

IN HANDY ROUND PINTS

At Abbotts and Jane Logan Dealers

Abbotts Dairies, Inc.

Just one prescription for Engran Term-Pak
SQUIBB VITAMIN-MINERAL SUPPLEMENT *(270 tablets)*
calling for just one tablet per day will carry her through term to the six-week postpartum check-up. Thus, you help to assure a nutritionally perfect pregnancy, while providing the convenience and economy of the re-usable Term-Pak. Engran is also available in bottles of 100 tablets.

SQUIBB *Squibb Quality—The Priceless Ingredient*

'ENGRAN'® AND 'TERM-PAK'® ARE SQUIBB TRADEMARKS

. . . MALNUTRITION OR
LEG CRAMPS DURING PREGNANCY?

OUTMODED AS GODEY'S FASHIONS!

Rx NEW

PRENALIN-O®

PRENATAL SUPPLEMENT

1. Oyster Shell Calcium - Phosphorus Free!
2. New Form of Iron!
3. Dry Filled Capsule - Sure, Quick Absorption!
4. Economical Once-A-Day Dosage!
5. Wider Range Nutritional Support!
6. Relieves Troublesome Leg Cramps!

EACH dry filled capsule (lavender and white) provides:

Ferrous Fumarate (Iron)	150 mg.	Vitamin B-12 (Cobalamin conc. NF)	2 mcg.
Deep sea oyster shell (Calcium)	600 mg.	Folic Acid	0.25 mg.
Vitamin C	50 mg.	Niacinamide	10 mg.
Vitamin A	4000 USP Units	Vitamin K (Menadione)	0.25 mg.
Vitamin D	400 USP Units	Rutin	10 mg.
Vitamin B-1	2 mg.	Sodium Molybdate	3 mg.
Vitamin B-2	2 mg.	Fluorine (Calcium Fluoride)	0.25 mg.
Vitamin B-6	0.8 mg.	Iodine (Potassium Iodide)	0.15 mg.

SAMPLES ON REQUEST

TUTAG

S. J. TUTAG & CO.

DETROIT 34, MICHIGAN

RADON • RADIUM

SEEDS • IMPLANTERS • CERVICAL APPLICATORS

THE RADIUM EMANATION CORPORATION

GRAYBAR BUILDING • NEW YORK 17, N. Y.

Wire or Phone MUrray Hill 3-8636 Collect

CHANGE OF ADDRESS

In the event of a change of address or failure to receive THE JOURNAL regularly fill out this coupon and mail at once to

THE MEDICAL SOCIETY OF NEW JERSEY, P. O. Box 904, Trenton 5, N. J.

Change my address on mailing list

From .....

To .....

Date..... Signed..... M.D.

Now —All cold symptoms can be controlled

Tussagesic

timed-release *tablets*

Controls congestion
with Triaminic,[1,2,3] the leading oral nasal decongestant.

Controls aches and fever
with well-tolerated APAP, non-addictive analgetic[4] and excellent antipyretic.[5]

Each TUSSAGESIC Tablet provides:

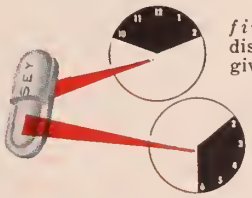
TRIAMINIC® .....50 mg.
(phenylpropanolamine HCl .....25 mg.
pheniramine maleate .....12.5 mg.
pyrilamine maleate .....12.5 mg.)
Dormethan
(brand of dextromethorphan HBr)..... 30 mg.
Terpin hydrate .....180 mg.
APAP (N-acetyl-p-aminophenol) .....325 mg.

References: 1. Lhotka, F. M.: Illinois M. J. 112:259 (Dec.) 1957. 2. Fabricant, N. D.: E.E.N.T. Monthly 37:460 (July) 1958. 3. Farmer, D. F.: Clin. Med. 5:1183 (Sept.) 1958. 4. Bonica, J. J.: in Drugs of Choice, Mosby, St. Louis, 1958, p. 272. 5. Dascomb, H. E.: in Current Therapy, Saunders, Phila., 1958, p.78. 6. Bickerman, H. A.: in Drugs of Choice, Mosby, St. Louis, 1958, p.547.

Controls cough centrally
with non-narcotic Dormethan, possessing "amply demonstrated" antitussive activity,[6] as effective as codeine.

Liquefies tenacious mucus
with terpin hydrate, classic expectorant.

Prompt and prolonged relief because of this special "timed release" design:



first — the outer layer dissolves within minutes to give 3 to 4 hours of relief

then — the inner core releases its ingredients to sustain relief for 3 to 4 more hours

Dosage: One tablet in the morning, midafternoon and at bedtime. Pediatric dosage chart for Tussagesic Suspension available on request.

TUSSAGESIC SUSPENSION provides palatability and convenience which make it especially attractive to children and other patients who prefer liquid medication.

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska

MENIC™

C.N.S. stimulant

cerebral vasodilator

in the

senility syndrome

cerebral arteriosclerosis

and **mental confusion**

Each scored tablet contains pentylenetetrazole 100 mg. (1½ gr.) nicotinic acid 50 mg. (5/6 gr.) in bottles of 100 and 500 tablets. Usual dose: 2 MENIC tablets t.i.d., p.c.

Literature and samples available upon request.

MENIC combines the mutually enhancing action of the effective analeptic, pentylenetetrazole, with the proven cerebral vasodilator, nicotinic acid.

MENIC acts to increase oxygen and blood supply to the brain and so helps to overcome the cerebral ischemia and hypoxia responsible for many senility symptoms. Produced physical, mental and social improvement.[1] Menic makes possible a more comfortable, happier life.

1. Levy, S.: J.A.M.A. 153:1260, 1953.

GERIATRIC

GERIATRIC PHARMACEUTICAL CORP.
BELLEROSE, L. I., N. Y.
Pioneers in Geriatric Research

HOTEL ESSEX HOUSE

1050 Broad Street at Lincoln Park
Newark, New Jersey

A. C. ALLAN, General Manager

•

Largest and Most Complete Catering, Banquet, Ballroom, and Meeting Facilities
All Function Rooms Air Conditioned

•

HOME OF

THE "CAROUSEL"

Newark's Most Beautiful Cocktail Lounge and Supper Club

and

THE CHARCOAL CORNER

•

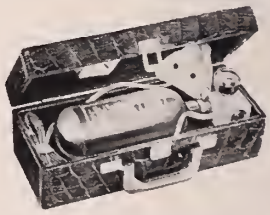
For inquiries and reservations
Telephone Mitchell 2-4400

Now... EMERGENCY OXYGEN

in your car and office

When symptoms call for oxygen administer it "on the spot," while waiting for additional oxygen to arrive, with

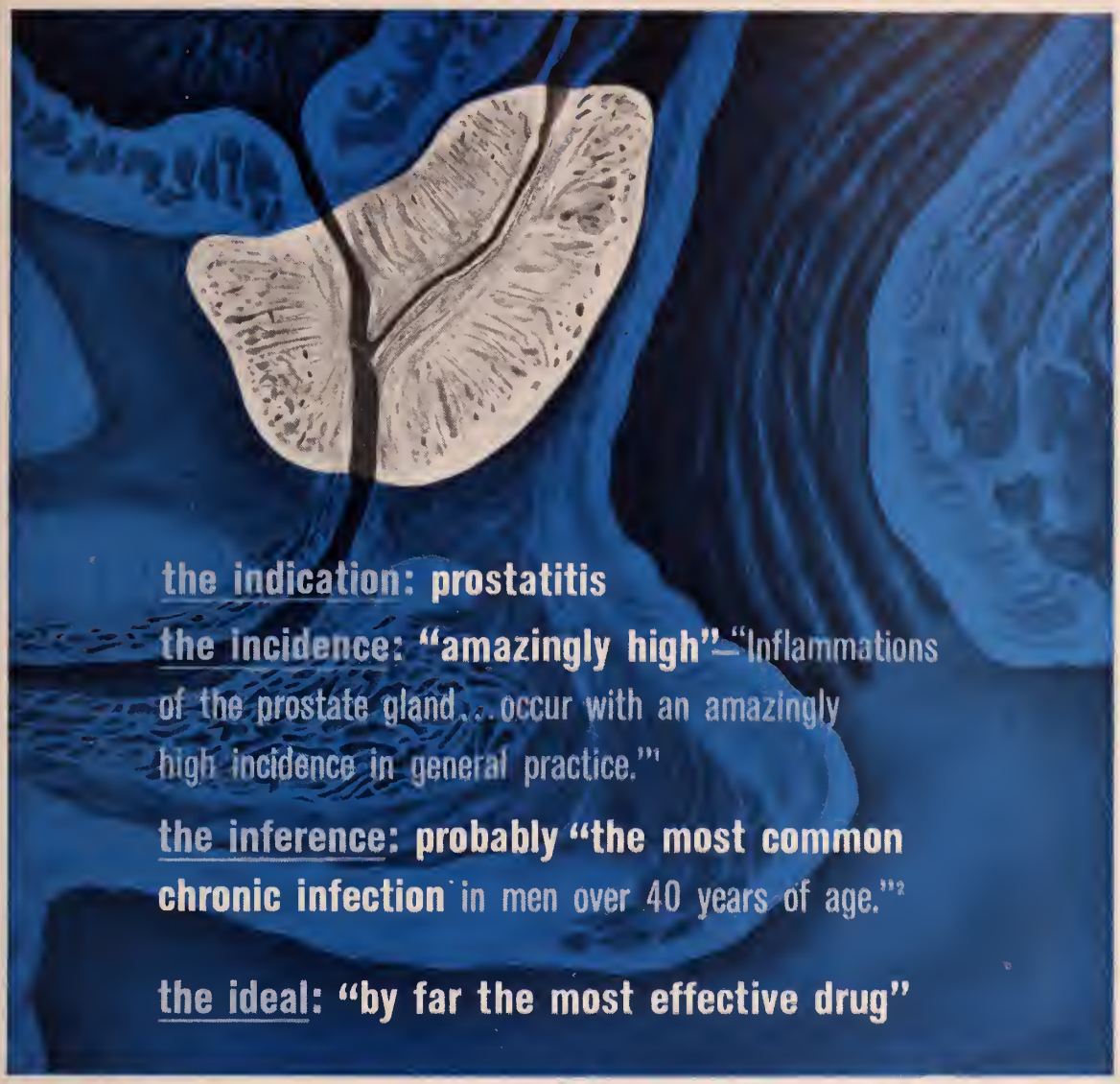
OXYGEN INHALATOR KIT



in compact, professional type, carrying case
SAFE — PORTABLE — REFILLABLE
Write or phone for Free Literature and Prices

OXYGEN KIT CO.

P.O. BOX 243 HANOVER, N. J.
Phone TUcker 7-1188



Furadantin®

brand of nitrofurantoin

"... by far the most effective drug to be employed, and this has been substantiated in practice. It is a drug of low toxicity and, what is more important, bacteria rarely if ever become resistant to it. It can be employed for long periods of time, is bactericidal and does not favor the appearance of monilial infections."[3]

Indicated in: acute and chronic prostatitis ▪ benign prostatic hypertrophy (to prevent or treat concomitant infection) ▪ postoperatively in prostatic surgery

Supplied: Tablets, 50 and 100 mg., Oral Suspension, 25 mg. per 5 cc. tsp.

References: 1. Campbell, M. F.: Principles of Urology, Philadelphia, W. B. Saunders Co., 1957. 2. Farman, F., and McDonald, D. F.: Brit. J. Urol. **31**:176, 1959. 3. Sanjurjo, L. A.: Med. Clin. N. America **43**:1601, 1959.

EATON LABORATORIES, NORWICH, NEW YORK

PRESCRIPTION PHARMACISTS

TO THE MEMBERS OF

The Medical Society of New Jersey

PLACE	NAME AND ADDRESS	TELEPHONE
BELLEVILLE	Joralemon Pharmacy, 531 Joralemon St.	PLym'th 9-4535-9858
BERGENFIELD	Horn's Pharmacy, 475 So. Washington Ave.	DUmont 4-1119
BERGENFIELD	Merit Pharmacy, 8 So. Washington Ave.	DUmont 4-9844
BOONTON	Preston Drugs, Del's Village Shopping Center	DEerfield 4-3466
BOUND BROOK	Lloyd's Drug Store, 305 East Main St.	ELliot 6-0150
BUTLER	Pink's Pharmacy, 178 Main St.	BUtler 9-0090, 9-1063
CLIFTON	Fleischner's Pharmacy, 652 Allwood Road	PRescott 7-6689
CLOSTER	Mid Town Pharmacy, 237 Closter Dock Road	CLoster 5-0070
DOVER	Leslie's Drugs, Inc., 9 East Blackwell St.	FOxcroft 6-1405
DUMONT	Lenrow's Pharmacy Inc., 10 W. Madison Ave.	DUmont 4-0842-1500
EDISON TOWNSHIP	Walter's Pharmacy, 1034 Amboy Ave.	LIberty 8-2614
EMERSON	Emerson Pharmacy, 201 Kinderkamack Road	COlfax 2-4999
FLEMINGTON	Green's Pharmacy, 52 Main St.	FLemington 108
FORDS	Fords Pharmacy, Inc., 550 New Brunswick Ave.	HIllcrest 2-4568
GLOUCESTER	King's Pharmacy, Broadway and Market Sts.	GLouc't'r 6-0781-8970
HAWTHORNE	Melcon's Pharmacy, 207 Diamond Bridge Ave.	HAwthorne 7-1546
HIGHLANDS	Highlands Pharmacy, 148 Bay Ave.	HIghlands 3-1058
JERSEY CITY	The Cole Pharmacy, Inc., 710 Grand St.	Delaware 3-9294
JERSEY CITY	J. B. Feinberg Pharmacy, 659 Newark Ave.	OLdfield 3-6376
JERSEY CITY	Honiberg Drug & Surgical Supply Co., 618 Newark Ave.	SWarthmore 8-6700
JERSEY CITY	Lauria's Pharmacy, 768 West Side Ave.	HEnderson 3-1519
JERSEY CITY	S. Taube Inc., 250 Jackson Ave.	HEnd'rs'n 3-2606-0642
JERSEY CITY	Waters Pharmacy, 492 Jackson Ave.	DElaware 3-3043
LAKEWOOD	Alpert's Pharmacy, 224 Clifton Ave., Cor. 3rd St.	FOxcroft 3-3600
LITTLE FALLS	Swisher Pharmacy, Inc., 94 Main St.	CLifford 6-0835
MILLTOWN	Milltown Pharmacy, 21 No. Main St.	MIlltown 8-0081
MILLVILLE	Richard H. Knowles Pharmacy, 600 No. High St.	TAylor 5-0721
MOORESTOWN	Stiles' Pharmacy, 75 East Main St.	BElmont 5-0088
MORRISTOWN	Carrell's Pharmacy (N. E. Corrao, Pharm.) 31 South St.	JEfferson 9-0143
MORRISVILLE, PA.	Pryor's Pharmacy, Bridge St. & Penna. Ave.	CYpress 5-7416
MOUNT HOLLY	Goldy's Pharmacy, Main & Washington Sts.	AMherst 7-2250
MOUNT HOLLY	Mount Holly Pharmacy, 64 Main St.	AMherst 7-0453
NEWARK	Marquier's Pharmacy, Sanford & So. Orange Aves.	ESsex 3-7721
NEWARK	Smith's Pharmacy, 315 So. Orange Ave.	MArket 3-1514

(Continued on following page)

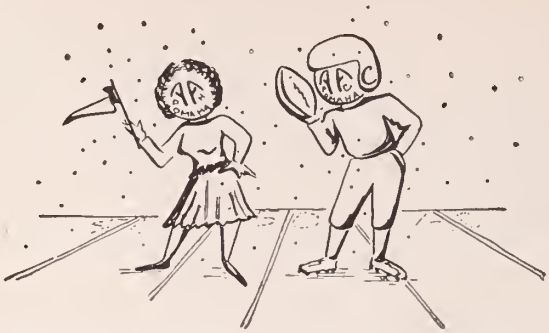
PRESCRIPTION PHARMACISTS

TO THE MEMBERS OF

The Medical Society of New Jersey

(Continued from preceding page)

NEW BRUNSWICK	Bode Drug Co., 120 French St.	KIlmer 5-2676
NEW BRUNSWICK	Hoagland's Drug Store, 365 George St.	KIlmer 5-0048
NEW BRUNSWICK	Rutgers Pharmacy, 429 Livingston Ave.	CHarter 9-6666
NEW BRUNSWICK	Tobin's Drug Store, 335 George St.	CHarter 9-0780
NEW BRUNSWICK	Zajac's Pharmacy, 225 George St.	KIlmer 5-0582
OCEAN CITY	Selvagn's Pharmacy, 862 Asbury Ave.	OCean City 3535
ORANGE	Highland Pharmacy, 536 Freeman St.	ORange 3-1040
ORANGE	Hollywood Pharmacy, 49 Central Ave.	ORange 5-1752
PASSAIC	Wollman Pharmacy, 143 Prospect St.	PRescott 9-0081
PATERSON	Vallario's Pharmacy, 357 Totowa Ave.	ARmory 4-2139
PAULSBORO	Nastase's Pharmacy, 762 Delaware St.	PAulsboro 8-1569
PERTH AMBOY	Jacobs' Drug Store, 434 Amboy Ave.	VAlley 6-3273
PITMAN	Lodge's Pharmacy, 39 So. Broadway	LUther 9-2392
PRINCETON	The Thorne Pharmacy, 168 Nassau St.	WAlnut 4-0077
RAHWAY	Kirstein's Pharmacy, 74 East Cherry St.	RAhway 7-0235
RIDGEFIELD PARK	Lloyd's Prescriptions, 209 Main St.	DIamond 2-8383
RIDGEWOOD	Davis Pharmacy, Inc., 2 Wilsey Square	OLiver 2-2444
ROCKAWAY	Leslie's Drugs, Inc., 36 West Main St.	OAkwood 7-5544
RUMSON	Rumson Pharmacy, W. E. Fogelson	RUmson 1-1234
SOMERDALE	Balaban's Pharmacy, Maiden Lane & White Horse Pike	STerling 3-2956
SOUTH AMBOY	Madura Pharmacy, 115 N. Broadway	PArkway 1-1732
SOUTH ORANGE	Taft's Pharmacy, 2 South Orange Ave.	SOuth Orange 2-0063
TRENTON	Adams & Sickles, State & Prospect Sts.	OWen 5-6396
TRENTON	Delahanty's Pharmacy, State St. at Chambers	EXport 3-4261
TRENTON	Episcopo's Pharmacy, Chambers & Liberty Sts.	EXport 3-3017
TRENTON	Foy's Drug Store, 3024 So. Broad St.	EXport 3-2367
TRENTON	H. S. Hughes, Thatcher Pharmacy, 401 Hudson St.	EXport 2-5616
TRENTON	Kehr's Pharmacy, A. F. Capriotti, R. P., M.P.A.	OWen 5-6807
TRENTON	Lee's Sun Ray Pharmacy, 940 Parkway Ave.	TUxedo 2-3456
UNION	Perkins Union Center Pharmacy	MUrdock 6-0877
UNION CITY	Husni's Pharmacy, 2503 Bergenline Ave.	UNion 5-2577
UNION CITY	Jos. Parentini's Pharmacy, Inc., Charles H. Arnoldi	UNion 7-4806
VENTNOR	Barsky Drugs, Inc., 5217 Atlantic Ave.	ATlantic City 2-1177
WEST NEW YORK	The Owl Pharmacy, 6611 Bergenline Ave.	UNion 5-0384
WEST ORANGE	West Orange Pharmacy, 443 Main St.	ORange 4-9824
WRIGHTSTOWN	Bowen's Pharmacy, 152 Fort Dix Road	RAymond 3-2176



Protection against loss of income from accident and sickness as well as hospital expense benefits for you and all your eligible dependents.

PHYSICIANS CASUALTY & HEALTH ASSOCIATIONS

OMAHA 31, NEBRASKA

ALL PREMIUMS COME FROM — PHYSICIANS SURGEONS DENTISTS — ALL BENEFITS GO TO

Since 1902
Handsome Professional Appointment Book sent to you FREE upon request.

Today's Health
published by the American Medical Association

A GOOD BUY IN PUBLIC RELATIONS

Today's Health is published for the American Family by the American Medical Association

GIVE GIFT SUBSCRIPTIONS to your patients and friends

Today's Health - AMA
535 N. Dearborn Street
Chicago 10, Illinois

Please enter the following subscription:

☐ 2 YEARS $5.00 ☐ 1 YEAR $3.00
(U.S., U.S. POSSESSIONS & CANADA)

Name _____

Address _____

City _____ Zone _____ State _____

Please Print--Use separate sheet for additional names. SJ

The Children's Country Home

An accredited 54-bed specialized hospital for handicapped children. Especially equipped for care of cardiac pre- and postoperative cases, cerebral palsy, polio, congenital defects, rheumatoid arthritis, Legg-Perthes' diseases and other orthopedic conditions. Our services include physical therapy and pool treatments, x-ray, occupational and speech therapy. Regular schooling is provided.
The referring physician may continue to prescribe treatment or may transfer responsibility to our staff.

* * *

New Providence Road
Westfield, New Jersey

THE ORANGE PUBLISHING CO., Inc.

PRINTERS

116-118 LINCOLN AVENUE
ORANGE, NEW JERSEY
Phone OR 3-0048

FAIR OAKS

SUMMIT, NEW JERSEY

An 80 bed private psychiatric hospital for intensive treatment specializing in the latest therapeutic techniques plus electro-shock and insulin coma therapy. Write

THOMAS P. PROUT, Jr.
Administrator

OSCAR ROZETT, M.D.
Medical Director
P. SINGER, M.D.
E. SOKAL, M.D.
ELIZABETH ROZSA, M.D.
M. E. NEUMAN, M.D.
Associates

Tel. CRestview 7-0143

The Glenwood Sanitarium

LICENSED FOR THE CARE AND TREATMENT OF

NERVOUS AND MENTAL DISORDERS
ALCOHOLISM AND DRUG ADDICTION

Homelike surroundings, good nursing psychiatric treatment, including shock therapy and excellent food.

R. GRANT BARRY, M.D.

2301 NOTTINGHAM WAY TRENTON, N. J.
JUniper 7-1210

PHONE
CH. 2-2330

for well trained highly qualified personnel

MEDICAL
OFFICE ASSISTANTS OR SECRETARIES

Co-Ed (Founded 1936)
N. Y. State Licensed Day-Eve. Courses
Trained by Physicians for Physicians

Eastern *request Free Cat. 7*

SCHOOL FOR PHYSICIANS' AIDES
85 Fifth Ave. (16th St.) New York 3, N. Y.
affiliated with CARNEGIE INSTITUTE. INC. *Cleveland, O.*

HALL-BROOKE HOSPITAL

An Active Treatment Hospital, located one hour from New York

Accredited by: The Central Inspection Board of the American Psychiatric Association
The Joint Commission on Accreditation of Hospitals

HALL-BROOKE, GREENS FARMS, BOX 31, CONN.

Telephone: WESTPORT CAPITAL 7-1281

George S. Hughes, M.D.
Leo H. Berman, M.D.
Albert M. Moss, M.D.
Louis J. Micheels, M.D.
Robert Isenman, M.D.
John D. Marshall, Jr., M.D.
Edward M. Keelan, M.D.
Peter P. Barbara, Ph.D.

CLASSIFIED ADVERTISEMENTS

WANTS FOR SALE TO LET

SITUATIONS ETC.

Send replies to box number c/o **The Journal** P. O. Box 904, Trenton 5, N. J.

$3.00 for 25 words or less: additional words 5c each Forms close 15th of the Preceding Month.

GENERAL PRACTITIONER—Young, energetic to take over established—good year-round plus heavy seasonal—practice at New Jersey shore. Call SEaside Park 9-0263.

INDUSTRIAL PHYSICIAN—Large Phila. industrial firm has immediate opening in its Medical Division for a physician to assist in the implementation of its Employe Medical Program. Headquarters in Phila. with some travel. Licensed or eligible for licensing in Penna. Send full details of education, experience, etc. to H. A. Smith, P.O. Box 7258, Phila. I, Pa. All replies will be held in strictest confidence.

ASSISTANT TO MEDICAL DIRECTOR—for 280-bed County, accredited Hospital. Requirements, experience in Chest Diseases, Internal Medicine (Geriatrics); New Jersey State license. Modern furnished accommodation and full maintenance at nominal cost; excellent pension plan combined with Social Security, also free hospitalization, paid vacation, sick leave and holidays. Salary depending on experience and qualifications. Contact Eugene Nargiello, M.D., Superintendent and Medical Director, John E. Runnells Hospital for Chest Diseases, Berkeley Heights, New Jersey.

SENIOR PHYSICIAN—for 280-bed County, accredited Hospital. Requirements, approved internship and training in Chest Diseases, experience in Internal Medicine (Geriatrics); eligible for license in New Jersey or licensed in any State. Modern furnished accommodation and full maintenance at nominal cost; excellent pension plan combined with Social Security, also free hospitalization, paid vacation, sick leave and holidays. Salary depending on training and experience. Contact Eugene Nargiello, M.D., Superintendent and Medical Director, John E. Runnells Hospital for Chest Diseases, Berkeley Heights, New Jersey.

WANTED TO LET—5-room professional office in Montclair, N. J. Write Box GL, c/o THE JOURNAL.

BOARD CERTIFIED INTERNIST-GASTROENTEROLOGIST would like to sublet fully equipped office in Montclair, N. J. Write Box IG, c/o THE JOURNAL.

NEW MEDICAL SUITES AVAILABLE in excellent location; at line of Hudson & Bergen Counties. One-story building with parking; all modern conveniences supplied. $160-$175/mos. Bergenline Professional Bldg., 8609 Bergenline Ave., North Bergen, N. J. UN. 9-0850.

LAKELAND AREA, NORTHERN NEW JERSEY —Opportunity to take over 20 year established general practice vacant due to illness. Will discuss office rental, partnership, etc. with interested physicians. For details contact: Mrs. J. J. Cartisser, High St., Stanhope, N. J. NEtcong 2-0258.

NEW, AIR-CONDITIONED, FIRST FLOOR OFFICE AVAILABLE—with parking facilities; flexible room arrangement; desirable Madison location, near hospital, shopping center and bus lines. Call HU. 2-3443 or FR. 7-7746.

UNUSUAL OPPORTUNITY—Professional Bldg., Montclair, New Jersey. Every advantage. Very low rental. Dr. Mearin—PI 4-5657.

IN MONTCLAIR—2 or 3 large rooms, ideal location, air-conditioned. Separate entrance. Parking facilities. PI. 4-2030.

NEWARK—Doctor's office established 30 years. 694 Clinton Avenue. First floor, 3-room suite. Garage. Phone ESsex 3-4823.

PARAMUS MEDICAL ARTS BUILDING being built now. Leasing space for medical and dental specialties. CO 1-0877. Dr. Hershey, 330 Fairview Ave., Paramus, N. J.

(Continued on following page)

CLASSIFIED ADVERTISEMENTS

(Continued from preceding page)

PLAINFIELD, N. J., 1310 West 7th St.—Two suites available, newly built professional building. Wood paneled waiting room, nurses' station, 3 examination rooms one suite, and 2 examination rooms the other suite. Private lavatories, central heating and air conditioning, on site parking. Rent reasonable. Call WAverly 6-3238. One suite now occupied by dentist.

RUTHERFORD, N. J.—5 rm. office, Pvt. street entrance. Centrally located luxury elevator building. Suitable MD or DDS. Available for immediate occupancy. Briar Hall Apts., 130 Orient Way. GEneva 8-6700 or WEbster 9-3139.

SUMMIT OFFICE—Best location, spacious, well-arranged, redecorated; furnished equipped. Ideal for pediatrics, medicine, general; suitable any field. Adequate parking. Write Box WB, c/o THE JOURNAL.

FOR SALE OR RENT—Eight-room house ideal location for doctor's office and family. Call after 6 p.m. or write Mr. Arnold Lubetkin, 317 Elmora Ave., Elizabeth, N. J. Phone EL 5-2152.

FOR SALE—General practice in industrial city of 40,000 in Northern New Jersey; hospitals nearby; modern brick house with office combined. No dermatologist in town. Write Box LI, c/o THE JOURNAL.

FOR SALE—South Jersey shore area. Will sacrifice home, office, tremendous general practice for real estate value. Leaving for residency. High income assured. Will finance. Write Box FH, c/o THE JOURNAL.

EQUIPMENT FOR SALE—Jones Motor Basal; Dr. Young's — Wappler Cystoscopy Set and Young's X-ray Table complete. All in good condition. Reasonable. Write Box KN, c/o THE JOURNAL.

THE CRANE PLAN is the fruit of 30 years experience and research in billing and collecting current and past due accounts for members of The Medical Society of New Jersey.

CRANE DISCOUNT CORP.
Executive Offices
221 WEST 41st STREET
NEW YORK 36, N. Y.

CARDIOLOGY
Postgraduate Course

HAHNEMANN MEDICAL COLLEGE and HOSPITAL

THURSDAYS 1:30 to 3:30 P.M.

30 Sessions October through May

This course is divided into three sections dealing with three important phases of Cardiology, designed especially for the General Practitioner.

Section 1. Electrocardiography (30 Hours)
Section 2. Cardiac Auscultation (20 Hours)
Section 3. Special Graphic Methods in Heart Disease (10 Hours)

The sections of the course may be taken individually or as a group. Acceptable as Category I credit for AAGP postgraduate education requirements.

Detailed information forwarded on request to:

LOWELL L. LANE, M.D.
CARDIOVASCULAR SECTION
HAHNEMANN HOSPITAL
PHILADELPHIA 2, PENNA.

TEMPLE UNIVERSITY MEDICAL CENTER

PRESENTS The 4TH ANNUAL POSTGRADUATE COURSE

RECENT ADVANCES IN MEDICINE

11:00 A.M. to 4:00 P.M.
ON 8 Consecutive Wednesdays
from
October 19 to December 7, 1960

The course will consist of seminars, panel discussions, clinics, lectures and ward rounds considering subjects of interest to the family physician. Several distinguished out of state authorities will participate.

ENROLLMENT LIMITED REGISTRATION FEE: $50.00

Acceptable for Category I credit by A.A.G.P.

For Further Information and Curriculum, write to:

Department of Medicine
Temple University Hospital, Phila. 40, Pa

THOMAS M. DURANT, M.D.
Professor
ALBERT J. FINESTONE, M.D.
Director of Postgraduate Course

VIRTUALLY NO DECREASE IN STAPHYLOCOCCAL SENSITIVITY

OVER AN 8-YEAR SPAN . . . TO

CHLOROMYCETIN

(chloramphenicol, Parke-Davis)

An outstanding and frequently reported characteristic of CHLOROMYCETIN[1-8] "...is the fact that the very great majority of the so-called resistant staphylococci are susceptible to its action."[1] In describing their study, Rebhan and Edwards[2] state that "...only a small percentage of strains have shown resistance..." to CHLOROMYCETIN, despite steadily increasing use of the drug over the years.

Fisher[3] observes: "The over-all average incidence of resistance, for the 31,779 strains [of staphylococci] through nine years was about 9%." Finland[4] reports that, while the proportion of strains resistant to several newer antibiotics has risen to between 10 and 30 per cent, such resistance to CHLOROMYCETIN "...has been rare even where this agent has been used extensively." Numerous other investigators concur in these findings.[5-8]

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in various forms, including Kapseals® of 250 mg., in bottles of 16 and 100.

CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

References: (1) Welch, H., in Welch, H., & Finland, M.: Antibiotic Therapy for Staphylococcal Diseases, New York, Medical Encyclopedia, Inc., 1959, p. 1. (2) Rebhan, A. W., & Edwards, H. E.: *Canad. M. A. J.* **82**:513, 1960. (3) Fisher, M. W.: *Arch. Int. Med.* **105**:413, 1960. (4) Finland, M., in Welch, H., & Finland, M.: Antibiotic Therapy for Staphylococcal Diseases, New York, Medical Encyclopedia, Inc., 1959, p. 187. (5) Bercovitz, Z. T.: *Geriatrics* **15**:164, 1960. (6) Glas, W. W., & Britt, E. M.: Management of Hospital Injections, in Symposium on Antibacterial Therapy, Michigan & Wayne County Acad. Gen. Pract., Detroit, September 12, 1959, p. 7. (7) Staphylococcal Infections in Pediatrics, Scientific Exhibit, Commission on Professional and Hospital Activities, 108th Ann. Meet., A. M. A., Atlantic City, June 8-12, 1959. (8) Robinson, H. M., Jr.; Robinson, R. C. V., & Raskin, J.: *Postgrad. Med.* **27**:522, 1960.

ITRO SENSITIVITY OF PYOGENIC STRAINS OF STAPHYLOCOCCI TO CHLOROMYCETIN OVER A PERIOD OF EIGHT YEARS*

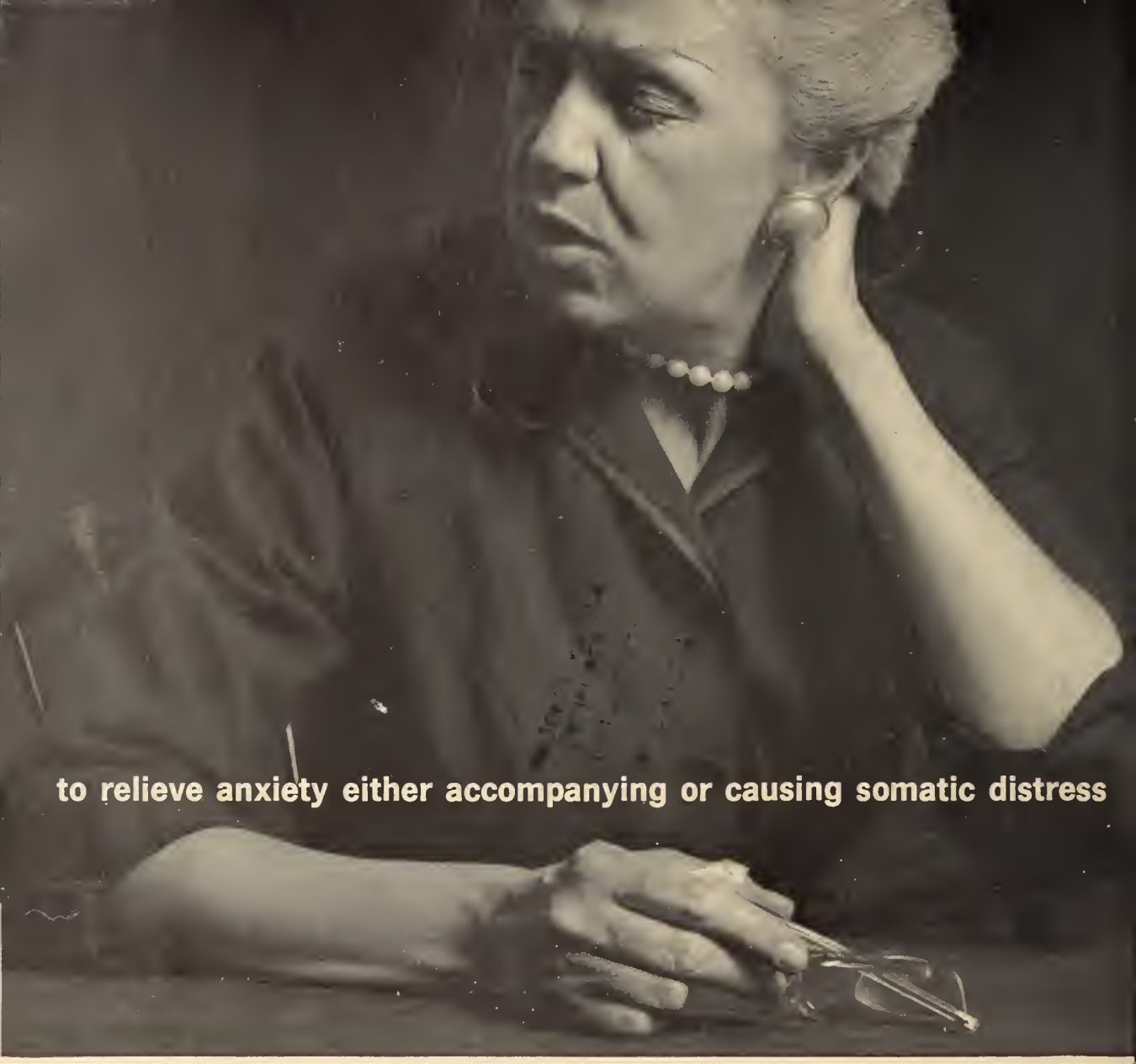
istics were gathered over almost a decade on 329 children with staphylococcal pneumonia; 1,663 sensitivity tests were performed.

pted from Rebhan & Edwards.[2]

10060

RKE, DAVIS & COMPANY · Detroit 32, Michigan

PARKE-DAVIS



advantages you can expect to see with Stelazine®

brand of trifluoperazine

- **Prompt control of the underlying anxiety.** Beneficial effects are often seen within 24-48 hours.
- **Amelioration of somatic symptoms.** Marx[1] reported from his study of 43 office patients that 'Stelazine' "appeared to be effective for patients whose anxiety was associated with organic—as well as functional disorders."
- **Freedom from lethargy and drowsiness.** Winkelman[2] observed that 'Stelazine' "produces a state approaching ataraxia without sedation which is unattainable with currently available neuroleptic agents; its freedom from lethargy and drowsiness makes ['Stelazine'] extremely well accepted by patients."

Optimal dosage: 2-4 mg. daily. Available as 1 mg. and 2 mg. tablets, in bottles of 50 and 500.

N.B.: For further information on dosage, side effects, cautions and contraindications, see available comprehensive literature, *Physicians' Desk Reference*, or your S.K.F. representative. Full information is also on file with your pharmacist.

1. Marx, F.J., in *Trifluoperazine: Further Clinical and Laboratory Studies*, Philadelphia, Lea & Febiger, 1959, p. 89.
2. Winkelman, N.W., Jr.: *ibid.*, p. 78.

SMITH KLINE & FRENCH

THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

Entered as second-class matter September 5, 1906, at the post office at Orange, New Jersey, under Act of March 3, 1879

Second Class Postage Paid at Orange, N. J.

VOL. 57, NO. 10 — OCTOBER, 1960 — Subscription $3.00 per Year, Single Copies, 30 Cents

LIBRARY OCT 20 1960 NEW YORK ACADEMY OF MEDICINE

CONTENTS—Pages 559 to 612

EDITORIALS— Page

- **Diabetes Detection Week** ... 559
- **Blue Shield as a Whipping Boy** ... 560
- **Out of the Rut** ... 560
- **Executive Health: A New Medical Specialty** 561

ORIGINAL ARTICLES—

- **A Full-Time Psychiatrist in the General Hospital**—Morris Parmet, M.D., Flemington, N. J. ... 562
- **Syphilis Today**—Edmond Edelson, M.D., Newark, N. J. ... 566
- **Diseases of the Lower Bowel in Older People**—Richard A. Hopping, M.D., East Orange, N. J. ... 571
- **A Safe Effective Anesthesia for Cystoscopies**—Alexander Karfopoulos, M.D., Bayonne, N. J. ... 576
- **Pseudo-Retardation**—Bernard R. Goldberg, M.D., Newark, N. J. ... 579

ORIGINAL ARTICLES— Page

- **Traumatic Rupture of the Bladder**—Herbert D. Axilrod, M.D., Atlantic City, N. J. ... 584
- **Correct Diagnosis in Treating Skin Diseases**—Otto B. Hitschmann, M.D., Newark, N. J. ... 587
- **Successful Long-Term Weight Loss**—L. P. Lapin, M.D., Bordentown, N. J. ... 590

STATE ACTIVITIES—

- Board of Trustees: June 26, 1960 ... 593
- Woman's Auxiliary Program ... 597

OBITUARIES ... 599

MEDICAL-SURGICAL PLAN DISCUSSION ... 600

COUNTY SOCIETY REPORTS ... 607

ANNOUNCEMENTS ... 608

BOOK REVIEWS ... 609

NTA ABSTRACTS ... 611

Roster of Officers and Committee Chairmen, Advertising Page 3A

Place of Publication, Printing and Mailing, 116-118 Lincoln Ave., Orange, N. J.

Editorial and Executive Offices of the Society 315 West State St., Trenton 8, N. J.

Address all communications FOR PUBLICATION to editorial office at P.O. Box 904, Trenton 5, N. J.

Telephone EXport 4-3154

Published Monthly Since 1904

Acceptance for mailing at special rate of postage provided for in Sec. 1103, Act of Oct. 3, 1917, authorized July 29, 1918.

Copyright 1960 by The Medical Society of New Jersey

THE NEW LIFE INSURANCE PLAN

officially endorsed by

THE MEDICAL SOCIETY OF NEW JERSEY

WHAT YOUR PLAN OFFERS

FIRST UNIT OF $10,000 of 5-year renewable and convertible term life insurance issued on a short health statement WITHOUT MEDICAL EXAMINATION, but subject to the company's underwriting rules of selection, PLUS as much as $40,000 additional life insurance subject to a physical examination.

PREMIUMS DO NOT CHANGE during each 5-year period.

RATES LOWER THAN you can obtain individually and guaranteed for the life of your policy with premiums reducible by dividends as declared by the company.

COVERAGE GUARANTEED non-cancellable even if you retire or move.

GUARANTEED RIGHT TO CONVERT to any permanent plan AT ANY TIME without evidence of insurability.

DOUBLE INDEMNITY for accidental death included without extra charge.

WAIVER OF PREMIUM for total and permanent disability prior to age 60 without extra charge.

MORE THAN 1,700 MEMBERS OF THE STATE SOCIETY ARE PRESENTLY INSURED UNDER THIS PROGRAM.

WHAT YOUR PLAN COSTS FOR EACH $10,000 UNIT

(Your age at the beginning of each five year term determines the premiums for each year during that term.)

YOUR AGE (nearest birthday)	ANNUAL	SEMI-ANNUAL
29 and under	$ 50.00	$ 25.50
30	60.00	30.60
31	63.00	32.10
32	65.00	33.20
33	67.00	34.20
34	70.00	35.70
35	73.00	37.20
36	77.00	39.30
37	80.00	40.80
38	83.00	42.30
39	87.00	44.40
40	90.00	45.90
41	93.00	47.40
42	96.00	49.00
43	99.00	50.50
44	103.00	52.50
45	107.00	54.60
46	113.00	57.60
47	124.00	63.20
48	136.00	69.40
49	143.00	75.50
50	160.00	81.60
51	175.00	89.30
52	185.00	94.40
53	195.00	99.50
54	205.00	104.60
55	230.00	117.30
56	250.00	127.50
57	265.00	135.20
58	280.00	142.80
59	295.00	150.50
60	315.00	160.70
61	330.00	168.30
62	345.00	176.00
63	360.00	183.60
64	375.00	191.30
65	405.00	206.60

Issued and renewed for successive 5 year terms beginning before 65th birthday. Insurance coverage then continuable through conversion.

Administered by:

E. & W. BLANKSTEEN AGENCY, INC.

75 Montgomery St., Jersey City 2, N. J. • Telephone: Delaware 3-4340

Underwritten by Nationwide Life Insurance Company of Columbus, Ohio

Highest rating in Best's Insurance Reports with more than 1½ billions of life insurance in force.

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766

PLACE OF PUBLICATION, PRINTING AND MAILING, 116 LINCOLN AVE., ORANGE, N. J.

EXECUTIVE AND EDITORIAL OFFICES, 315 WEST STATE STREET, TRENTON 8, N. J. Tel. EXport 4-3154

(MAILING ADDRESS: P.O. BOX 904, TRENTON 5, N. J.)

Mr. Richard I. Nevin, *Executive Officer* ..... Trenton
Mrs. Edith L. Madden, *Administrative Secretary and Convention Manager* ..... Trenton
Henry A. Davidson, *Editor* ..... Cedar Grove
Mrs. Miriam N. Armstrong, *Assistant Editor* ..... Trenton

OFFICERS

President, Jesse McCall ..... Newton
President-Elect, Ralph M. L. Buchanan ..... Phillipsburg
First Vice-President, Louis S. Wegryn ..... Elizabeth
Second Vice-President, Carl N. Ware ..... Shiloh
Secretary, Marcus H. Greifinger ..... Newark
Treasurer, Daniel F. Featherston ..... Ashury Park

TRUSTEES

Luke A. Mulligan, *Chairman* (1962) ..... Leonia
Jerome G. Kaufman, *Secretary* (1961) ..... Newark
Jesse McCall ..... Newton
Ralph M. L. Buchanan ..... Phillipsburg
Louis S. Wegryn ..... Elizabeth
Carl N. Ware ..... Shiloh
Marcus H. Greifinger ..... Newark
Daniel F. Featherston ..... Ashury Park
F. Clyde Bowers ..... Mendham
David B. Allman (1962) ..... Atlantic City
John J. Bedrick (1963) ..... Bayonne
Nicholas A. Bertha (1962) ..... Wharton
C. Byron Blaisdell (1961) ..... Ashury Park
Louis K. Collins (1961) ..... Glassboro
Lloyd A. Hamilton (1962) ..... Lamhertville
Frank J. Hughes (1963) ..... Gloucester
Joseph R. Jehl (1963) ..... Clifton
Samuel J. Lloyd (1963) ..... Trenton

COUNCILORS

First District (Union, Warren, Morris and Essex Counties) ..... Emanuel M. Satulsky, Elizabeth (1963)
Second District (Sussex, Bergen, Hudson and Passaic Counties) ..... John L. Olpp, Englewood (1962)
Third District (Mercer, Middlesex, Somerset and Hunterdon Counties) ..... Charles H. Calvin, Perth Amboy (1961)
Fourth District (Camden, Burlington, Ocean and Monmouth Counties) ..... E. Vernon Davis, Moorestown (1963)
Fifth District (Cape May, Cumberland, Atlantic, Gloucester and Salem Counties) ..... Isaac N. Patterson, Westville (1962)

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Delegates

C. Byron Blaisdell (1960) ..... Asbury Park
William F. Costello (1961) ..... Dover
Aldrich C. Crowe (1961 ..... Ocean City
J. Wallace Hurff (1960) ..... Newark
L. Samuel Sica (1960) ..... Trenton
Elmer P. Weigel (1960) ..... Plainfield

Alternates

Ralph M. L. Buchanan (1960) ..... Phillipsburg
Joseph P. Donnelly (1961) ..... Jersey City
Elton W. Lance (1961) ..... Rahway
Jesse McCall (1960) ..... Newton
Herschel Pettit (1960) ..... Ocean City
John H. Rowland (1960) ..... New Brunswick

DELEGATES TO OTHER STATES

New York—William F. Costello (1961) ..... Dover
Connecticut—Lloyd A. Hamilton (1961) ..... Lamhertville
New York—Levi M. Walker (1961) ..... Atlantic City
Connecticut—S. Eugene Dalton (1961) ..... Ventnor

COMMITTEE CHAIRMEN — 1960-61

Annual Meeting ..... Jerome G. Kaufman, Newark
..... Vice-Chairman—Edward E. P. Seidmon, Plainfield
Cancer Control ..... John L. Olpp, Englewood
Child Health ..... Robert E. Jennings, South Orange
Chronically Ill and Aging ..... William H. Hahn, Newark
Constitution and Bylaws ..... Louis F. Albright, Spring Lake
..... Vice-Chairman—Joseph M. Gannon, Plainfield
Credentials ..... M. H. Greifinger, Newark
..... Vice-Chairman—Eugene J. Tyrrell, Perth Amboy
Disaster Medical Services ..... R. Winfield Betts, Medford
Finance and Budget ..... David B. Allman, Atlantic City
..... Vice-Chairman—Carl N. Ware, Shiloh
Hearing and Speech ..... S. Eugene Dalton, Ventnor
Honorary Membership ..... Aldrich C. Crowe, Ocean City
..... Vice-Chairman—Royal A. Schaaf, Califon
Industrial Health ..... Willis B. Mitchell, Toms River
Legislation ..... C. Byron Blaisdell, Asbury Park
..... Vice-Chairman—A. Guy Campo, Westville
Maternal and Infant Welfare ..... John D. Preece, Trenton
Medical Defense and Insurance ..... Daniel F. Featherston, Asbury Park
..... Vice-Chairman—Benjamin F. Slobodien, Perth Amboy
Medical Education ..... Sherman Garrison, Jr., Bridgeton
..... Vice-Chairman—Morris H. Saffron, Passaic
Medical Services ..... Irving Klompus, Bound Brook
..... Vice-Chairman—Nicholas E. Marchione, Vineland
Medical Student Loan Fund ..... Luke A. Mulligan, Leonia
..... Vice-Chairman—Vincent P. Butler, Jersey City
Mental Health ..... John J. Mackin, Jersey City
Physicians Placement Service ..... Samuel J. Lloyd, Trenton
Publication ..... Fred B. Rogers, Trenton
..... Vice-Chairman—C. Spencer Davison, Salem
Public Health ..... Robert S. Garher, Belle Mead
..... Vice-Chairman—John B. Fuhrmann, Flemington
Public Relations ..... John F. Kustrup, Trenton
..... Vice-Chairman—John J. Torppey, Newark
Rehabilitation ..... Elmer J. Elias, Trenton
Scientific Exhibit ..... Milton Ackerman, Atlantic City
Scientific Program ..... Edward E. P. Seidmon, Plainfield
Traffic Safety ..... A. M. K. Maldeis, Camden
Vision ..... Samuel M. Diskan, Atlantic City
Woman's Auxiliary ..... Lewis C. Fritts, Somerville
..... Vice-Chairman—A. Guy Campo, Westville
Workmen's Compensation ..... Joseph A. Lepree, Elizabeth

attains
sustains
retains

extra
antibiotic
activity

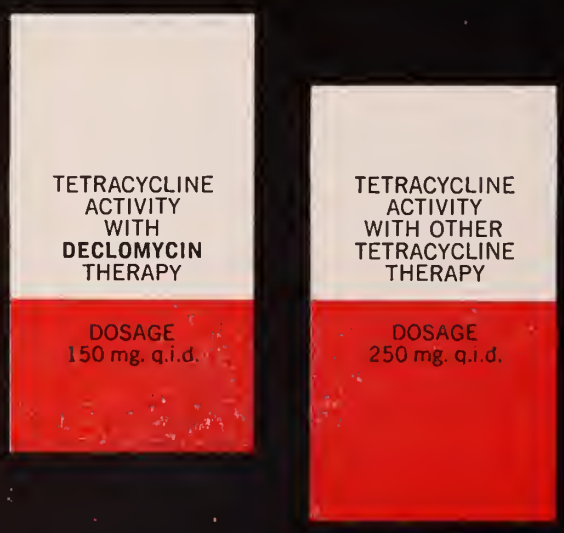
DEC

attains activity levels promptly

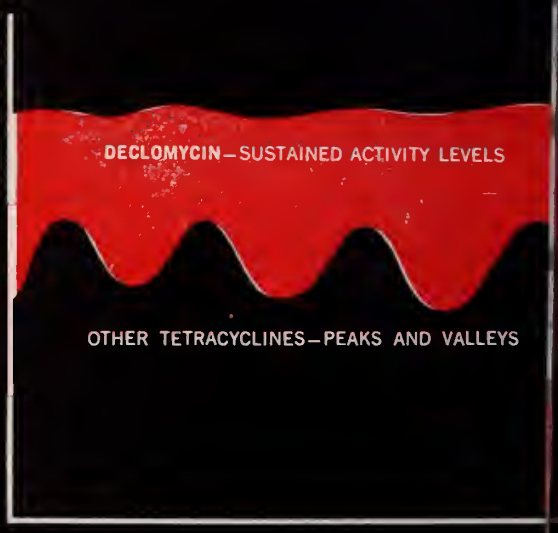
DECLOMYCIN Demethylchlortetracycline attains — usually within two hours—blood levels more than adequate to suppress susceptible pathogens — on daily dosages substantially lower than those required to elicit antibiotic activity of comparable intensity with other tetracyclines. The average, effective, adult daily dose of other tetracyclines is 1 Gm. With DECLOMYCIN, it is only 600 mg.

sustains activity levels evenly

DECLOMYCIN Demethylchlortetracycline sus through the entire therapeutic course, the high ity levels needed to control the primary infectio to check secondary infection at the original — another—site. This combined action is usually tained without the pronounced hour-to-hour, do dose, peak-and-valley fluctuations which ch terize other tetracyclines.



POSITIVE ANTIBACTERIAL ACTION



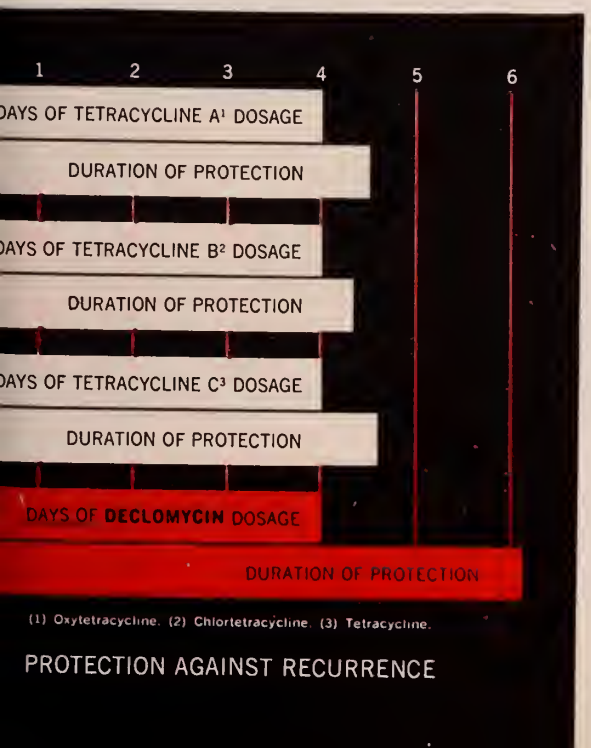
PROTECTION AGAINST PROBLEM PATHOGEN

LOMYCIN®

DEMETHYLCHLORTETRACYCLINE LEDERLE

tains activity
vels 24-48 hrs.

LOMYCIN Demethylchlortetracycline retains ac- / levels up to 48 hours after the last dose is n. At least a full, extra day of positive action may be confidently expected. The average, daily adult ıge for the average infection—1 capsule q.i.d.—ıe same as with other tetracyclines...but **total** ıge is lower and duration of action is longer.



CAPSULES, 150 mg., bottles of 16 and 100. **Dosage:** Average infections—1 capsule four times daily. Severe infections—Initial dose of 2 capsules, then 1 capsule every six hours.

PEDIATRIC DROPS, 60 mg./cc. in 10 cc. bottle with calibrated, plastic dropper. **Dosage:** 1 to 2 drops (3 to 6 mg.) per pound body weight per day—divided into 4 doses.

SYRUP, 75 mg./5 cc. teaspoonful (cherry-flavored), bottles of 2 and 16 fl. oz. **Dosage:** 3 to 6 mg. per pound body weight per day—divided into 4 doses.

PRECAUTIONS—As with other antibiotics, DECLOMYCIN may occasionally give rise to glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis or dermatitis. A photodynamic reaction to sunlight has been observed in a few patients on DECLOMYCIN. Although reversible by discontinuing therapy, patients should avoid exposure to intense sunlight. If adverse reaction or idiosyncrasy occurs, discontinue medication.

Overgrowth of nonsusceptible organisms is a possibility with DECLOMYCIN, as with other antibiotics. The patient should be kept under constant observation.

Lederle

LEDERLE LABORATORIES
A Division of
AMERICAN CYANAMID COMPANY
Pearl River, New York

Lifts depression...

You see an improvement within a few days
Thanks to your prompt treatment and the smooth action of Deprol, her depression is relieved and her anxiety and tension calmed – *often in a few days.* She eats well, sleeps well and soon returns to her normal activities.

as it calms anxiety!

Smooth, balanced action lifts depression as it calms anxiety... rapidly and safely

Balances the mood — no "seesaw" effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient —*they often aggravate anxiety and tension.*

And although amphetamine-barbiturate combinations may counteract excessive stimulation—*they often deepen depression.*

In contrast to such "seesaw" effects, Deprol's smooth, *balanced* action lifts depression as it calms anxiety—both at the same time.

Acts swiftly — the patient often feels better, sleeps better, within a few days. Unlike the delayed action of most other antidepressant drugs, which may take two to six weeks to bring results, Deprol relieves the patient quickly — often within a few days. Thus, the expense to the patient of long-term drug therapy can be avoided.

Acts safely — no danger of liver damage. Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function—frequently reported with other antidepressant drugs.

Bibliography *(13 clinical studies, 858 patients)*: **1.** Alexander, L. (35 patients): Chemotherapy of depression — Use of meprobomote combined with benoctyzine (2-diethylominoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. **2.** Bateman, J. C. and Carlton, H. N. (50 patients): Meprobomate and benoctyzine hydrochloride (Deprol) as adjunctive therapy for patients with advanced cancer. Antibiotic Med. & Clin. Therapy 6:648, Nov. 1959. **3.** Beerman, H. M. (44 patients): The treatment of depression with meprobomate and benoctyzine hydrochloride. Western Med. 1:10, March 1960. **4.** Bell, J. L., Tauber, H., Santy, A. and Pulita, F. (77 patients): Treatment of depressive states in office practice. Dis. Nerv. System 20:263, June 1959. **5.** Breitner, C. (31 patients): On mental depressions. Dis. Nerv. System 20:142, (Section Two), May 1959. **6.** Gardan, P. E. (50 patients): Deprol in the treatment of depression. Dis. Nerv. System 21:215, April 1960. **7.** Landman, M. E. (50 patients): Clinical trial of a new antidepressive agent. J. M. Soc. New Jersey. In press, 1960. **8.** McClure, C. W., Papos, P. N., Speare, G. S., Palmer, E., Slattery, J. J., Kanefol, S. H., Henken, B. S., Waad, C. A. and Ceresia, G. B. (128 patients): Treatment of depression — New technics and therapy. Am. Pract. & Digest Treat. 10:1525, Sept. 1959. **9.** Pennington, V. M. (135 patients): Meprobamate-benoctyzine (Deprol) in the treatment of chronic brain syndrome, schizophrenia and senility. J. Am. Geriatrics Soc. 7:656, Aug. 1959. **10.** Rickels, K. and Ewing, J. H. (35 patients): Deprol in depressive conditions. Dis. Nerv. System 20:364, (Section One), Aug. 1959. **11.** Ruchwarger, A. (87 patients): Use of Deprol (meprobamate combined with benoctyzine hydrochloride) in the office treatment of depression. M. Ann. District of Columbia 28:438, Aug. 1959. **12.** Settel, E. (52 patients): Treatment of depression in the elderly with a meprobamate-benoctyzine hydrochloride combination. Antibiotic Med. & Clin. Therapy 7:28, Jan. 1960. **13.** Splitter, S. R. (84 patients): Treatment of the anxious patient in general practice. J. Clin. & Exper. Psychopath. In press, April-June 1960.

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate. **Supplied:** Bottles of 50 light-pink, scored tablets. Write for literature and samples.

Deprol®

WALLACE LABORATORIES / *Cranbury, N. J.*

IN COLDS AND SINUSITIS— THE RIGHT AMOUNT OF "INNER SPACE" RIGHT AWAY

Neo-Synephrine hydrochloride relieves the boggy feeling of colds immediately and safely, without causing systemic toxicity or chemical harm to nasal membranes. Turbinates shrink, sinus ostia open, ventilation and drainage resume, and mouth-breathing is no longer necessary.

Gentle Neo-Synephrine shrinks nasal membranes for from two to three hours without stinging or harming delicate respiratory tissues. Post-therapeutic turgescence is minimal. Neo-Synephrine does not lose its effectiveness with repeated applications nor does it cause central nervous stimulation, jitters, insomnia or tachycardia.

Neo-Synephrine solutions and sprays produce shrinkage of tissue without interfering with ciliary activity or the protective mucous blanket.

For wide latitude of effective and safe treatment, Neo-Synephrine hydrochloride is available in nasal sprays for adults and children; in solutions from ⅛% to 1%; and in aromatic solution and water soluble jelly.

Winthrop LABORATORIES
New York 18, N. Y.

NEO-SYNEPHRINE®
(Brand of phenylephrine hydrochloride)
hydrochloride

NASAL SOLUTIONS AND SPRAYS

Arterial representation adapted from Recueil de Planches, Tome Second, Chez Pellet à Geneve, 1779

for more effective management of edema or hypertension an outstanding SALUTENSIVE saluretic and antihypertensive agent

saluron®

sustained-action hydroflumethiazide 'Bristol'

as an antihypertensive: "a distinct advantage in the manifestations of hypertension"[1]

. . . a superior foundation drug for an antihypertensive regimen . . . often the only drug required . . . in other cases, enhances the effect of tranquilizers, sympathetic depressants, and ganglionic blockers.

as a saluretic: "a marked advancement in the field of diuretic therapy"[2]

. . . prompt sodium excretion, with "a duration of at least 18 hours" on a single 50-mg. tablet[1]. . . repetitively effective.[1,3]

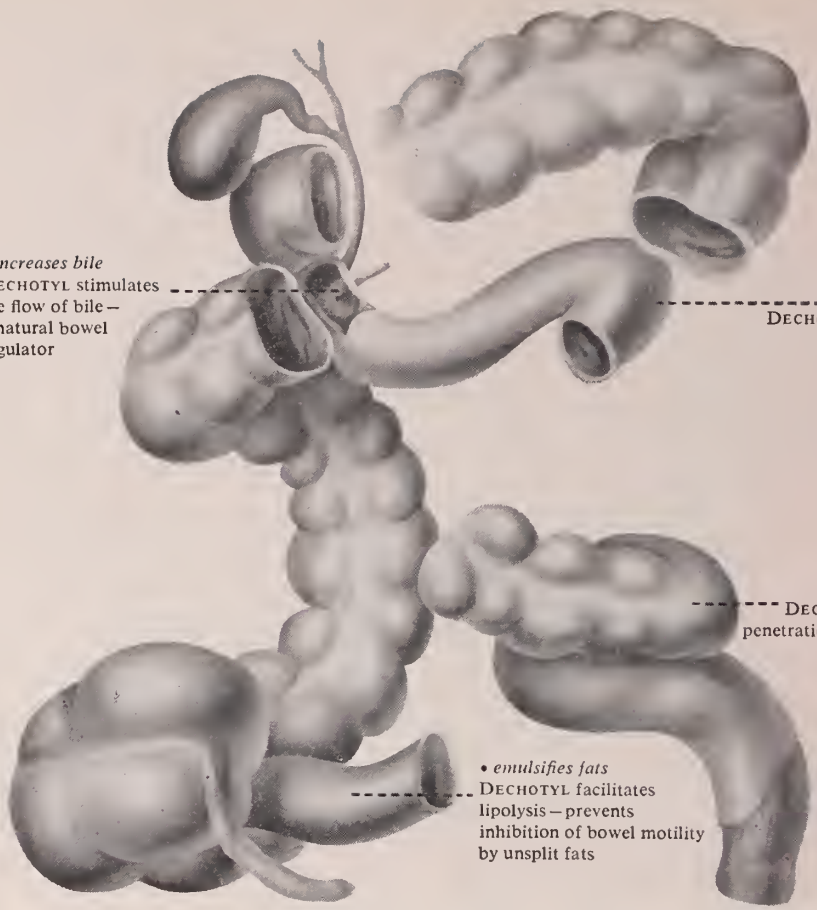
INDICATIONS: *Hypertension* and *hypertensive cardiovascular disease. Edema,* associated with cardiac or renal insufficiency, hepatic cirrhosis, pregnancy, premenstrual syndrome, or steroid administration.

DOSAGE: Usually 1 tablet daily. Full information in official package circular.

SUPPLY: Scored 50-mg. tablets; bottles of 50. Syrup, containing 50 mg. per 5-ml. teaspoonful; bottles of 8 fl. oz.

REFERENCES: 1. Ford, R. V., and Nickell, J.: Ant. Med. & Clin. Ther. 6:461, 1959. 2. Fuchs, M., and Mallin, S. R.: Int. Rec. Med. 172:438, 1959. 3. Ford, R. V.: Int. Rec. Med. 172:434, 1959.

BRISTOL LABORATORIES, SYRACUSE, NEW YORK



helps free your patient from both...
constipation and laxatives

DECHOTYL®

TRABLETS*

well tolerated...gentle transition to normal bowel function

Recommended to help convert the patient—naturally and gradually—to healthy bowel habits. Regimens of one week or more are suggested to assure maintenance of normal rhythm and to avoid the repetition of either laxative abuse or constipation.

Average adult dose: Two TRABLETS at bedtime as needed or as directed by a physician. *Action usually is gradual, and some patients may need 1 or 2* TRABLETS *3 or 4 times daily.*

Contraindications: Biliary tract obstruction; acute hepatitis.

DECHOTYL TRABLETS provide 200 mg. DECHOLIN,® (dehydrocholic acid, AMES), 50 mg. desoxycholic acid, and 50 mg. dioctyl sodium sulfosuccinate, in each trapezoid-shaped, yellow TRABLET. Bottles of 100.

*AMES T.M. for trapezoid-shaped tablet.

AMES
COMPANY, INC
Elkhart • Indiana
Toronto • Canada

84160

Note the two tablets on the shelf above. Left, old-style sugar-coated Dayalets-M®. Right, the same formula, but *Filmtab-coated*—potency's assured, but old-style bulk is cut 30%.

ON COATS:

STYLES CHANGE IN VITAMINS, TOO

Coat styles change—whether it's a blazer or a B-complex vitamin. Not long ago, for instance, "Vitamins by Abbott" were dressed up with a new-style coating—*Filmtab*®.

The most obvious result was a marked reduction in tablet size—up to 30% in some products. The tablets themselves were brilliant in a variety of rainbow colors. They wouldn't chip or stick together in the bottle. All vitamin tastes and odors—gone.

Such were the aesthetic gains. Behind these, a significant pharmaceutical advance: with Filmtab, deterioration is slowed to an irreducible minimum, because the coating process is essentially a water-free procedure.

Finally—most important—Filmtab guarantees that the content of each tablet matches the formula printed on the label. While the person taking the vitamins may not worry much about rigid stability, Abbott does. *Assures* it, through Filmtab.

In short, Filmtab's a name that stands for quality, stability, potency. The very best in vitamin coatings. Filmtab doesn't add a penny to the cost. And it's a name found *only* on

VITAMINS by ABBOTT

©1960, ABBOTT LABORATORIES

NEWEST
NUTRITIONAL
PRODUCT
FROM ABBOTT

To meet special nutritional needs of growing teenagers...

Filmtab® DAYTEENS
TRADEMARK

- RICH IN IRON, CALCIUM, VITAMINS—IMPORTANT FACTORS FOR THE GROWTH YEARS
- FILMTAB-COATED TO CUT SIZE AND ASSURE FULL POTENCY
- HANDSOME TABLE BOTTLES AT NO EXTRA COST (100-SIZE)
- ALSO SUPPLIED IN BOTTLES OF 250 AND 1000.

NOW, DAYTEENS JOINS THE COMPLETE LINE OF QUALITY VITAMINS BY ABBOTT:

FILMTAB
DAYALETS®
Table bottles of 100
Bottles of 50 and 250

FILMTAB
DAYALETS-M®
Apothecary bottles of 100 and 250

Extra-potent maintenance formulas—ideal for the "nutritionally run-down"

FILMTAB
OPTILETS®

FILMTAB
OPTILETS-M®
Table bottles of 30 and 100
Bottles of 1000

Therapeutic formulas for more severe deficiencies—illness, infection, etc.

FILMTAB
SUR-BEX® with C
Table bottle of 60
Bottles of 100, 500 and 1000

Therapeutic formula of the essential B-complex plus C, for convalescence, stress, post-surgery, etc.

EACH DAYTEENS FILMTAB® REPRESENTS:

Vitamin A	(5000 units) 1.5 mg.
Vitamin D	(1000 units) 25 mcg.
Thiamine Mononitrate (B_1)	2 mg.
Riboflavin (B_2)	2 mg.
Nicotinamide	20 mg.
Pyridoxine Hydrochloride	0.5 mg.
Vitamin B_{12} (as cobalamin concentrate)	2 mcg.
Calcium Pantothenate	5 mg.
Ascorbic Acid (C)	50 mg.
Iron (as sulfate)	10 mg.
Copper (as sulfate)	0.15 mg.
Iodine (as calcium iodate)	0.1 mg.
Manganese (as sulfate)	0.05 mg.
Magnesium (as oxide)	0.15 mg.
Calcium (as phosphate)	250 mg.
Phosphorus (as calcium phosphate)	193 mg.

VITAMINS by ABBOTT

ABBOTT

®FILMTAB—FILM-SEALED TABLETS, ABBOTT © 1960, ABBOTT LABORATORIES 009033B

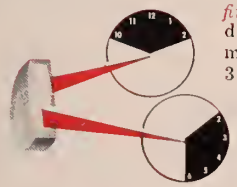
"Sometimes, I almost wish I were human so I could clear up this close-up, clogged-up nose of mine with TRIAMINIC®."

...and for humans with CLOGGED-UP NOSES...

Nasal congestion often persists with "bulldog tenacity." Nose drops and sprays often reach only the more superficial respiratory membranes and therefore fail to provide adequate relief. Furthermore, they may add to the patient's misery by producing rebound congestion, ciliary inhibition, and eventually "nose drop addiction." TRIAMINIC reaches *all* nasal and paranasal membranes *systemically* — provides more complete, longer-lasting relief while it avoids the harmful side effects associated with topical medication.

Indications: nasal and paranasal congestion, sinusitis, postnasal drip, upper respiratory allergy.

elief is prompt and prolonged
ecause of this special timed-release action:



first — the outer layer dissolves within minutes to produce 3 to 4 hours of relief

then — the core disintegrates to give 3 to 4 *more* hours of relief

Each Triaminic timed-release Tablet provides:

Phenylpropanolamine HCl	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

Dosage: 1 tablet in the morning, midafternoon and at bedtime. In postnasal drip, 1 tablet at bedtime is usually sufficient.

Each timed-release Triaminic Juvelet® provides:
½ the formulation of the Triaminic Tablet.
Dosage: 1 Juvelet in the morning, midafternoon and at bedtime.

Each tsp. (5 ml.) of Triaminic Syrup provides:
¼ the formulation of the Triaminic Tablet.
Dosage (to be administered every 3 or 4 hours):
Adults — 1 or 2 tsp.; *Children 6 to 12* — 1 tsp.;
Children 1 to 6 — ½ tsp.; *Children under 1* — ¼ tsp.

TRIAMINIC® *timed-release tablets, juvelets, and syrup*

STOP *running noses* *and open stuffed noses orally*

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska

limit the
blood pressure
swing

Rautrax-N lowers high blood pressure gently, gradually . . . protects against sharp fluctuations in the normal pressure swing. Rautrax-N combines Raudixin, the cornerstone of antihypertensive therapy, with Naturetin, the new, safer diuretic-antihypertensive agent. The complementary action of the components permits a lower dose of each thus reducing the incidence of side effects. The result: Maximum effectiveness, minimal dosage, enhanced safety. Rautrax-N also contains potassium chloride — for added protection against possible potassium depletion during maintenance therapy.

Supply: Rautrax-N — capsule-shaped tablets — 50 mg. Raudixin, 4 mg. Naturetin, and 400 mg. potassium chloride. Rautrax-N Modified — capsule-shaped tablets — 50 mg. Raudixin, 2 mg. Naturetin, and 400 mg. potassium chloride. For complete information write Squibb, 745 Fifth Avenue, New York 22, N. Y.

new Rautrax-N*

Squibb Standardized Whole Root Rauwolfia Serpentina (Raudixin) and Benzydroflumethiazide (*Naturetin) with Potassium Chloride

Squibb Quality—The Priceless Ingredient

SQUIBB

RAUDIXIN,® RAUTRAX,® AND NATURETIN® ARE SQUIBB TRADEMARKS

Raise the Pain Threshold

WITH MAXIMUM SAFE ANALGESIA

Phenaphen with Codeine provides intensified codeine effects with control of adverse reactions. It renders unnecessary (or postpones) the use of morphine or addicting synthetic narcotics, even in many cases of late cancer.

Three Strengths —

PHENAPHEN NO. 2
Phenaphen with Codeine Phosphate ¼ gr. (16.2 mg.)

PHENAPHEN NO. 3
Phenaphen with Codeine Phosphate ½ gr. (32.4 mg.)

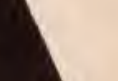
PHENAPHEN NO. 4
Phenaphen with Codeine Phosphate 1 gr. (64.8 mg.)

Also —

PHENAPHEN In each capsule

Acetylsalicylic Acid 2½ gr. .	(162 mg.)
Phenacetin 3 gr.	(194 mg.)
Phenobarbital ¼ gr.	(16.2 mg.)
Hyoscyamine sulfate	(0.031 mg.)

PHENAPHEN® WITH CODEINE



Robins

A. H. ROBINS CO., INC., RICHMOND 20, VIRGINIA

Ethical Pharmaceuticals of Merit since 1878

new clinical study[1] cites beneficial results in over 90% of cases in dry, itchy, scaly skin with Sardo®

in the bath

Use of **SARDO** in 118 dermatological patients to relieve dry, itchy, scaly, fissured skin achieved these excellent results:

CASES	AFTER SARDO*		
	Excellent	Good	Poor
49 Senile skin	32	13	4
26 Dry Skin in younger patients (diabetes, etc.)	14	11	1
20 Atopic dermatitis	8	10	2
13 Actinic changes	9	4	—
10 Ichthyosis	3	4	3
Skin Conditions	Benefited	No Benefit	
20 Nummular dermatitis	19	1	
10 Neurodermatitis	10	—	

SARDO acts[1,2] to (A) lubricate and soften skin, (B) replenish natural emollient oil, (C) prevent excessive evaporation of essential moisture.

SARDO releases millions of microfine water-miscible globules to provide a soothing suspension which enhances the efficacy of your other therapy.

SARDO is pleasant, convenient, easy to use; non-sticky, non-sensitizing. Bottles of 4, 8 and 16 oz.

1. Weissberg, G.: Clin. Med., June 1960.

2. Spoor, H. J.: N. Y. St. J. Med., Oct. 15, 1958.

**patent pending*
T.M. ©1960

for **SAMPLES** and complete reprint of Weissberg paper, please write . . .

Sardeau, Inc. 75 East 55th Street, New York 22, N. Y.

CLINICAL REMISSION IN A "PROBLEM" ARTHRITIC

In "escaping" rheumatoid arthritis. After gradually "escaping" the therapeutic effects of other steroids, a 52-year-old accountant with arthritis for five years was started on DECADRON, 1 mg./day. Ten months later, still on the same dosage of DECADRON, weight remains constant, she has lost no time from work, and has had no untoward effects. She is in clinical remission.*

New convenient b.i.d. alternate dosage schedule: the degree and extent of relief provided by DECADRON allows for b.i.d. maintenance dosage in many patients with so-called "chronic" conditions. Acute manifestations should first be brought under control with a t.i.d. or q.i.d. schedule.

Supplied: As 0.75 mg. and 0.5 mg. scored, pentagon-shaped tablets in bottles of 100. Also available as Injection DECADRON Phosphate. Additional information on DECADRON is available to physicians on request. DECADRON is a trademark of Merck & Co., Inc.

*From a clinical investigator's report to Merck Sharp & Dohme.

Decadron®

Dexamethasone

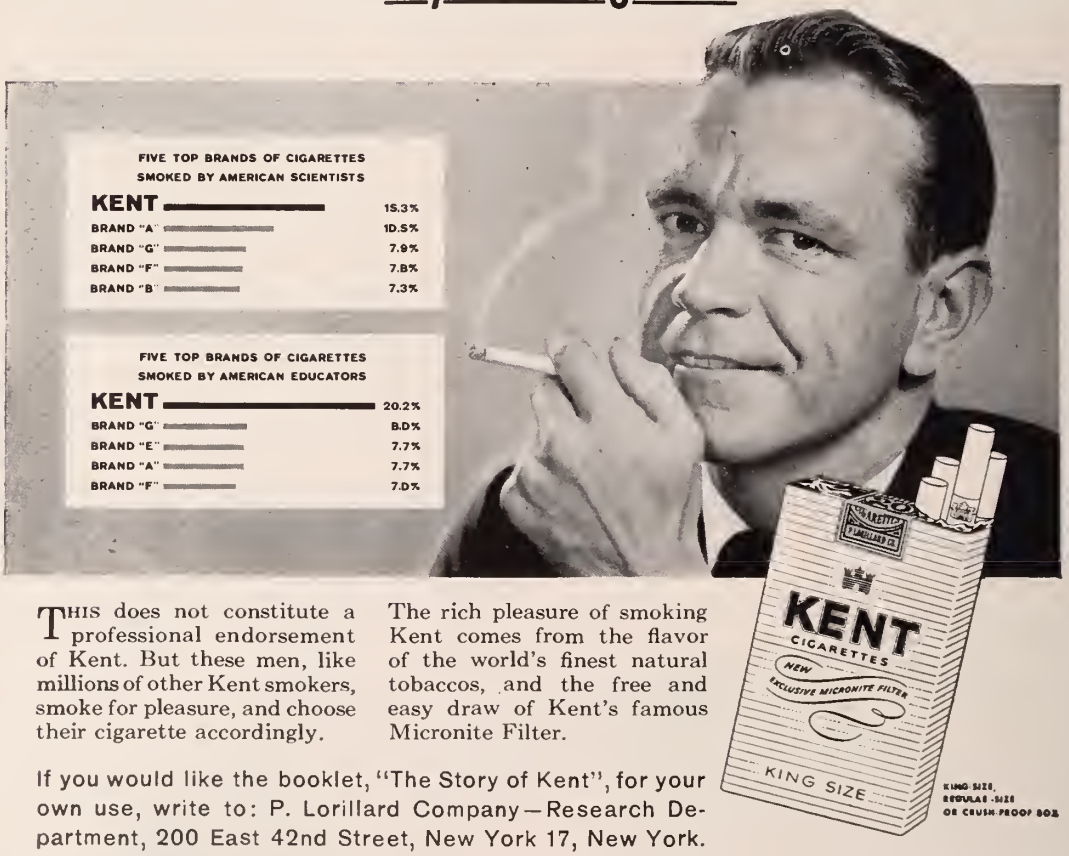
TREATS MORE PATIENTS MORE EFFECTIVELY

MSD MERCK SHARP & DOHME • Division of Merck & Co., INC., West Point, Pa.

ALL OVER AMERICA!

KENT with the MICRONITE FILTER IS SMOKED BY MORE SCIENTISTS and EDUCATORS

than any other cigarette!*



KING SIZE, REGULAR SIZE OR CRUSH-PROOF BOX

THIS does not constitute a professional endorsement of Kent. But these men, like millions of other Kent smokers, smoke for pleasure, and choose their cigarette accordingly.

The rich pleasure of smoking Kent comes from the flavor of the world's finest natural tobaccos, and the free and easy draw of Kent's famous Micronite Filter.

If you would like the booklet, "The Story of Kent", for your own use, write to: P. Lorillard Company—Research Department, 200 East 42nd Street, New York 17, New York.

For good smoking taste, it makes good sense to smoke KENT

*Results of a continuing study of cigarette preferences, conducted by O'Brien Sherwood Associates, N.Y., N.Y.

A PRODUCT OF P. LORILLARD COMPANY · FIRST WITH THE FINEST CIGARETTES THROUGH LORILLARD RESEARCH

© 1960, P. LORILLARD CO.

CONSISTENTLY GOOD
CLINICAL RESULTS
IN TRICHOMONAL
AND MONILIAL VAGINITIS

TRICOFURON IMPROVED (Suppositories and Powder) cured 143 of 161 patients with vaginitis due to Trichomonas vaginalis, Candida (Monilia) albicans, or both. "Almost immediate symptomatic improvement was noted with the first insufflation."

Criteria for cure: freedom from infecting organisms as well as symptoms on repeated examinations during a three-month follow-up. This cure rate of 88.8% is "surprisingly similar" to results reported by earlier investigators.

Coolidge, C. W.; Glisson, C. S., and Smith, A. S.: J.M.A. Georgia 48:167, 1959.

TRICOFURON®
IMPROVED

2-step treatment brings swift relief, eradicates stubborn trichomonads, Candida (Monilia) albicans, Hemophilus vaginalis

1. **POWDER** for weekly insufflation in your office. MICOFUR®, brand of nifuroxime, 0.5% and FUROXONE®, brand of furazolidone, 0.1% in an acidic water-dispersible base.

2. **SUPPOSITORIES** for continued home use —1st week one suppository in the morning and one on retiring. After 1st week, one suppository at night may suffice.

Continue use of suppositories during menses. Treatment should be continued throughout a complete menstrual cycle and for several days thereafter. MICOFUR 0.375% and FUROXONE 0.25% in a water-miscible base.

Rx new box of 24 suppositories with applicator for more practical and economical therapy. Also available: box of 12 suppositories with applicator.

NITROFURANS—a *unique* class of antimicrobials
EATON LABORATORIES, NORWICH, NEW YORK

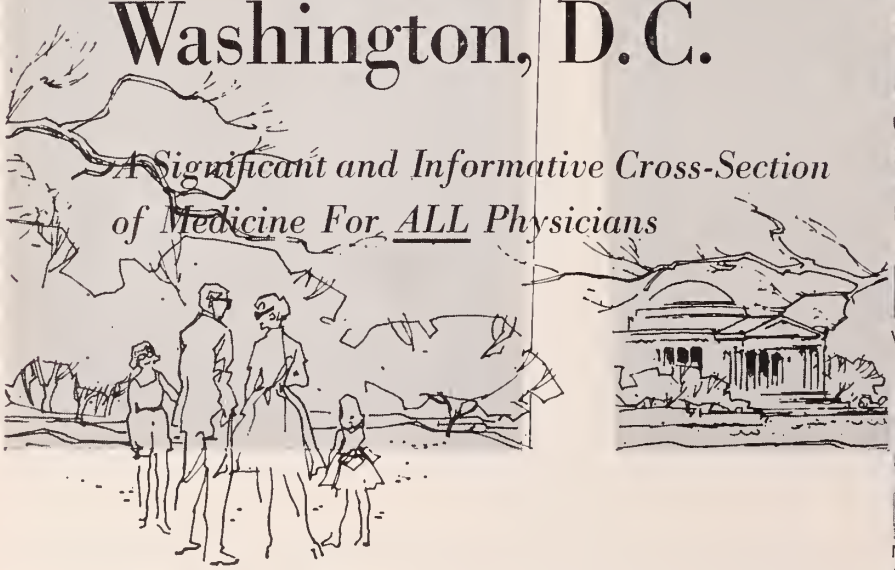
AMA

14th CLINICAL MEETING

November 28, 29, 30
December 1

Washington, D.C.

A Significant and Informative Cross-Section of Medicine For ALL Physicians

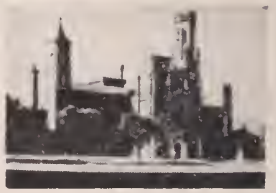


United States Capitol

White House

Mount Vernon

Lincoln Memorial



Smithsonian Institution

Our nation's historic capital city will be the setting for the American Medical Association's 14th Clinical Meeting November 28 through December 1.

The program—planned to interest and inform every physician—features the latest medical developments presented in panel discussions, symposiums, round table sessions, lectures, closed circuit telecasts and motion pictures. Many scientific and industrial exhibits will be on display.

AMERICAN MEDICAL ASSOCIATION

535 North Dearborn Street, Chicago 10, Illinois

Trancopal®

brand of chlormezanone

effective oral skeletal muscle relaxant and tranquilizer

LETS THE PATIENT WALK "HEADS UP" in spite of torticollis.

Trancopal

relieves pain and spasm associated with torticollis.

In a recent study by Ganz, Trancopal brought considerable improvement or very effective relief to 20 of 29 patients with torticollis.[1] "The patients helped by the drug," states Ganz, "were able to carry the head in the normal position without pain." Similarly, Kearney found that in 8 of 13 patients with chronic torticollis treated with Trancopal improvement was excellent to good. ". . . Trancopal is the most effective oral skeletal muscle relaxant and mild tranquilizer currently available."[2]

Lichtman, in a study of patients with various musculoskeletal conditions, noted that 64 of 70 patients with torticollis obtained excellent to good relief with Trancopal.[3]

In a comparative study of four central nervous system relaxants, Lichtman reports that 26 of 40 patients found Trancopal to be the most effective drug.[3]

1. Ganz, S. E.: *J. Indiana* 52:1134, July, 1959. 2. Kearney, *Current Therap. Res.* 2:127, 1960. 3. Lichtman, A. L.: *Ke* *Acad. Gen. Pract. J.* 4:28, Oct.,

Trancopal (brand of chlormezanone) and Caplets, trademarks reg. U. S. Pat. Off. 4716

Clinical results with *Trancopal*®

	Excellent	Good	Fair	Poor	Total
LOW BACK SYNDROMES					
Acute low back strain	25	19	8	6	58
Chronic low back strain	11	5	1	1	18
"Porters' syndrome"*	21	5	1	1	28
Pelvic fractures	2	1	—	—	3
NECK SYNDROMES					
Whiplash injuries	12	6	2	1	21
Torticollis, chronic	6	2	3	2	13
OTHER MUSCLE SPASM					
Spasm related to trauma	15	6	1	—	22
Rheumatoid arthritis	—	18	2	1	21
Bursitis	2	6	1	—	9
TENSION STATES	18	2	4	3	27
TOTALS	112 (51%)	70 (32%)	23 (10%)	15 (7%)	220 (100%

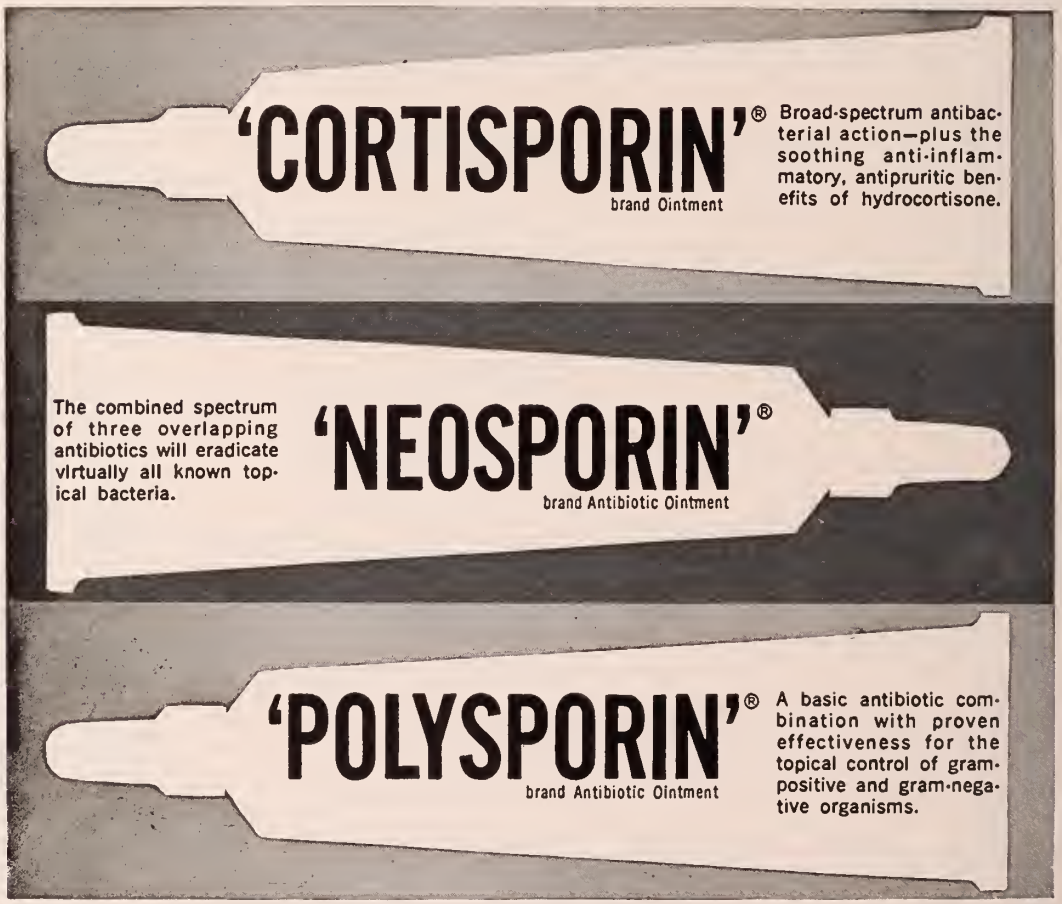
*Over-reaching in lifting heavy bags resulting in sprain of upper, middle, and lower back muscles.

Dosage: Adults, 200 or 100 mg. orally three or four times daily.
Relief of symptoms occurs in from fifteen to thirty minutes and lasts from four to six hours.

How Supplied: Trancopal Caplets®
200 mg. (green colored, scored), bottles of 100.
100 mg. (peach colored, scored), bottles of 100.

Winthrop LABORATORIES, New York 18, N. Y.

'B. W. & Co.' 'Sporin' Ointments rarely sensitize . . . give decisive bactericidal action for most every topical indication



Contents per Gm.	'Polysporin'®	'Neosporin'®	'Cortisporin'®
'Aerosporin'® brand Polymyxin B Sulfate	10,000 Units	5,000 Units	5,000 Units
Zinc Bacitracin	500 Units	400 Units	400 Units
Neomycin Sulfate	—	5 mg.	5 mg.
Hydrocortisone	—	—	10 mg.
Supplied:	Tubes of 1 oz., ½ oz. and ⅛ oz. (with ophthalmic tip)	Tubes of 1 oz., ½ oz. and ⅛ oz. (with ophthalmic tip)	Tubes of ½ oz. and ⅛ oz. (with ophthalmic tip)

BURROUGHS WELLCOME & CO. (U.S.A.) INC., Tuckahoe, New York

To the relief of musculoskeletal pain, new MEDAPRIN* adds restoration of function

Analgesics offer temporary relief of musculoskeletal pain, but they merely *mask* pain rather than getting at its *cause*. New Medaprin, in addition to bringing about prompt subjective improvement, promotes the *restoration of normal function* by suppressing the inflammation that *causes* the pain.

Medaprin, Upjohn's new analgesic-steroid combination, contains aspirin plus Medrol,** the corticosteroid with *the best therapeutic ratio in the steroid field.*† Instead of suffering recurrent discomfort because of the "wearing off" of analgesics, the patient on Medaprin experiences a smooth, *extended* relief and more normal mobility.

Indications: Medaprin is indicated in mild-to-moderate rheumatic and musculoskeletal conditions, including rheumatoid arthritis, deltoid bursitis, low back pain, neuralgia, synovitis, fibromyositis, osteoarthritis, low back sprain, traumatic wrist, sciatica, and "tennis elbow."

Dosage: The recommended dosage is 1 tablet q.i.d. The usual cautions and contraindications of corticotherapy should be observed.

Supplied: In bottles of 100 and 500.

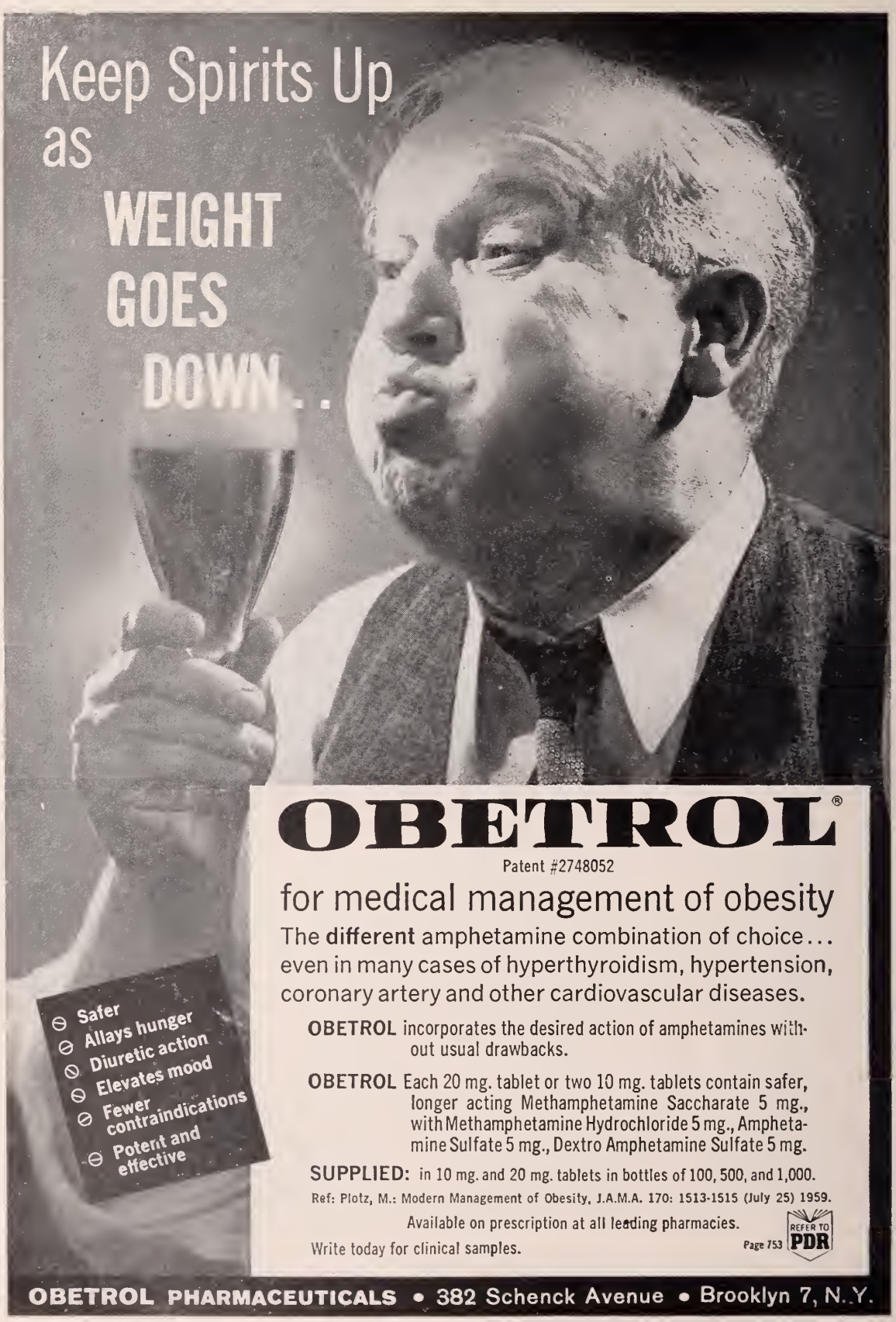
Formula: Each Medaprin tablet contains

- 300 mg. acetylsalicylic acid, for prompt relief of pain
- 1 mg. Medrol, to suppress the causative inflammation
- 200 mg. calcium carbonate, as buffer

*TRADEMARK **TRADEMARK, REG. U. S. PAT. OFF.—METHYLPREDNISOLONE, UPJOHN
†RATIO OF DESIRED EFFECTS TO UNDESIRED EFFECTS

The Upjohn Company, Kalamazoo, Michigan

Upjohn


Keep Spirits Up
as
WEIGHT
GOES
DOWN..
Safer
Allays hunger
Diuretic action
Elevates mood
Fewer contraindications
Potent and effective
OBETROL®
Patent #2748052
for medical management of obesity
The different amphetamine combination of choice... even in many cases of hyperthyroidism, hypertension, coronary artery and other cardiovascular diseases.
OBETROL incorporates the desired action of amphetamines without usual drawbacks.
OBETROL Each 20 mg. tablet or two 10 mg. tablets contain safer, longer acting Methamphetamine Saccharate 5 mg., with Methamphetamine Hydrochloride 5 mg., Amphetamine Sulfate 5 mg., Dextro Amphetamine Sulfate 5 mg.
SUPPLIED: in 10 mg. and 20 mg. tablets in bottles of 100, 500, and 1,000.
Ref: Plotz, M.: Modern Management of Obesity, J.A.M.A. 170: 1513-1515 (July 25) 1959.
Available on prescription at all leading pharmacies.
Write today for clinical samples.
REFER TO PDR
Page 753
OBETROL PHARMACEUTICALS • 382 Schenck Avenue • Brooklyn 7, N.Y.

THE ORIGINAL potassium phenethicillin

SYNCILLIN®

(phenoxyethyl penicillin potassium)

A dosage form to meet the individual requirements of patients of all ages in home, office, clinic, and hospital:

Syncillin Tablets — 250 mg. (400,000 units)... Syncillin Tablets — 125 mg. (200,000 units)
Syncillin for Oral Solution — 60 ml. bottles — when reconstituted, 125 mg. (200,000 units) per 5 ml.
Syncillin Pediatric Drops — 1.5 Gm. bottles. Calibrated dropper delivers 125 mg. (200,000 units)

Complete information on indications, dosage and precautions is included in the circular accompanying each package.

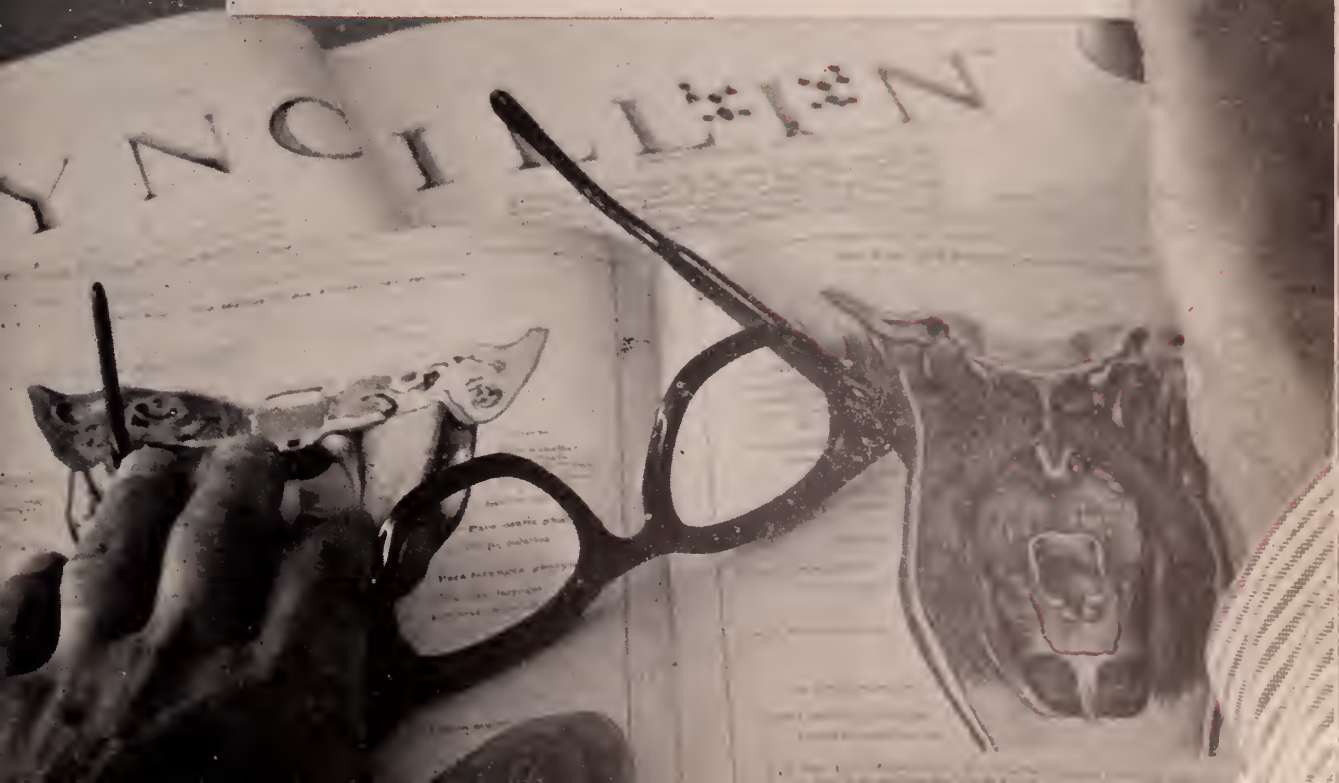
BRISTOL LABORATORIES, SYRACUSE, NEW YORK

ACUTE PHARYNGITIS

SYNCILLIN®
500 mg. t.i.d. - 5 days

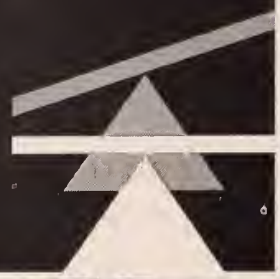
W. M. 24-year-old-male. Admitted with sore throat which had progressed rapidly in severity for 24 hrs. Temp. 104.4. Pulse 110. Acute pharyngitis and enlarged, red, bulging tonsils covered with pus. Throat culture revealed beta hemolytic strep. Patient given 500 mg. SYNCILLIN t.i.d. Within 24 hrs., fever terminated by crisis with marked relief of local signs and symptoms. After 5 days, infection was cured.

ctual case summary
from the files of
ristol Laboratories'
Medical Department



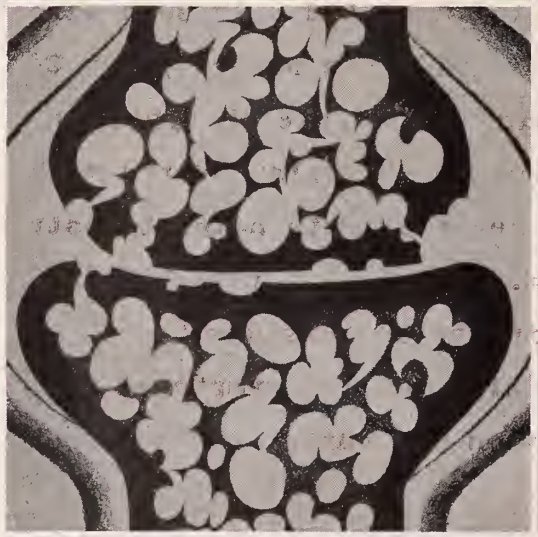
in rheumatic disorders

whenever aspirin proves inadequate



Sterazolidin®

brand of prednisone-phenylbutazone



Even in the more transient rheumatic disorders, an anti-inflammatory effect more potent than that provided by aspirin is often desirable to hasten recovery and get the patient back to work.
By combining the anti-inflammatory action of prednisone and phenylbutazone, Sterazolidin brings about exceptionally rapid resolution of inflammation with relief of symptoms and restoration of function.
Since Sterazolidin is effective in low dosage, the possibility of significant hypercortisonism, even in long-term therapy, is substantially reduced.

Availability: Each Sterazolidin® capsule contains prednisone 1.25 mg.; Butazolidin®, brand of phenylbutazone, 50 mg.; dried aluminum hydroxide gel 100 mg.; magnesium trisilicate 150 mg.; and homatropine methylbromide 1.25 mg. Bottles of 100 capsules.

Geigy, Ardsley, New York

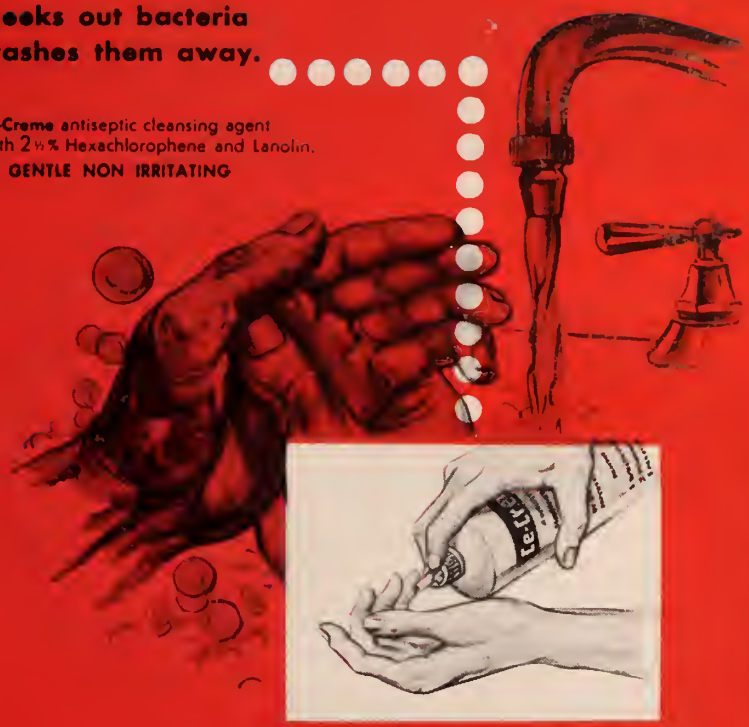
Geigy

165-60

Ce-Creme

seeks out bacteria washes them away.

Ce-Creme antiseptic cleansing agent with 2½% Hexachlorophene and Lanolin.
GENTLE NON IRRITATING



Ce-Creme

Ce-Creme – More effective scrub for the O.R.
Ce-Creme Combats Spread of hospital "Staph"
Ce-Creme – Useful in many skin conditions.

Apply to all parts of the body, on infants as well as adults.

6oz. & 16oz. squeeze-jet bottles 1 Gal. unbreakable plastic bottles.

for further information on Ce-Creme write to

CORNELL

PHARMACAL COMPANY, INC.
4504 Bergenline Ave.
UNION CITY, N. J.

Now...the only Nystatin combination with extra-active DECLOMYCIN®
Demethylchlortetracycline

with extra-broad spectrum benefits:— action at lower milligram intake...broad-range action...sustained peak activity... extra-day security against resurgence of primary infection or secondary invasion.

DECLOSTATIN®

Demethylchlortetracycline and Nystatin LEDERLE

CAPSULES, *150 mg. DECLOMYCIN Demethylchlortetracycline HCl and 250,000 units Nystatin.*
DOSAGE: *average adult, 1 capsule four times daily.*

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

In active people who won't take time to eat properly, MYADEC can help prevent deficiencies by providing comprehensive vitamin-mineral support. Just one capsule a day supplies therapeutic doses of 9 important vitamins plus significant quantities of 11 essential minerals and trace elements. MYADEC is also valuable in vitamin depletion and stress states, in convalescence, in chronic disorders, in patients on salt-restricted diets, or wherever therapeutic vitamin-mineral supplementation is indicated.

Each MYADEC Capsule contains: VITAMINS: Vitamin B_{12} crystalline—5 mcg.; Vitamin B_2 (riboflavin)—10 mg.; Vitamin B_6 (pyridoxine hydrochloride)—2 mg.; Vitamin B_1 mononitrate—10 mg.; Nicotinamide (niacinamide)—100 mg.; Vitamin C (ascorbic acid)—150 mg.; Vitamin A—(7.5 mg.) 25,000 units; Vitamin D—(25 mcg.) 1,000 units; Vitamin E (d-alpha-tocopheryl acetate concentrate)—5 I.U. MINERALS: (as inorganic salts) Iodine—0.15 mg.; Manganese—1 mg.; Cobalt—0.1 mg.; Potassium—5 mg.; Molybdenum—0.2 mg.; Iron—15 mg.; Copper—1 mg.; Zinc—1.5 mg.; Magnesium—6 mg.; Calcium—105 mg.; Phosphorus—80 mg. Bottles of 30, 100 and 250.

a quick "bite"...
then back
to the grind?
nutritional
deficiency's
not far behind.
prescribe...

Myadec®

high potency vitamin-mineral supplement

PARKE-DAVIS

PARKE, DAVIS & COMPANY
Detroit 32, Michigan

27260

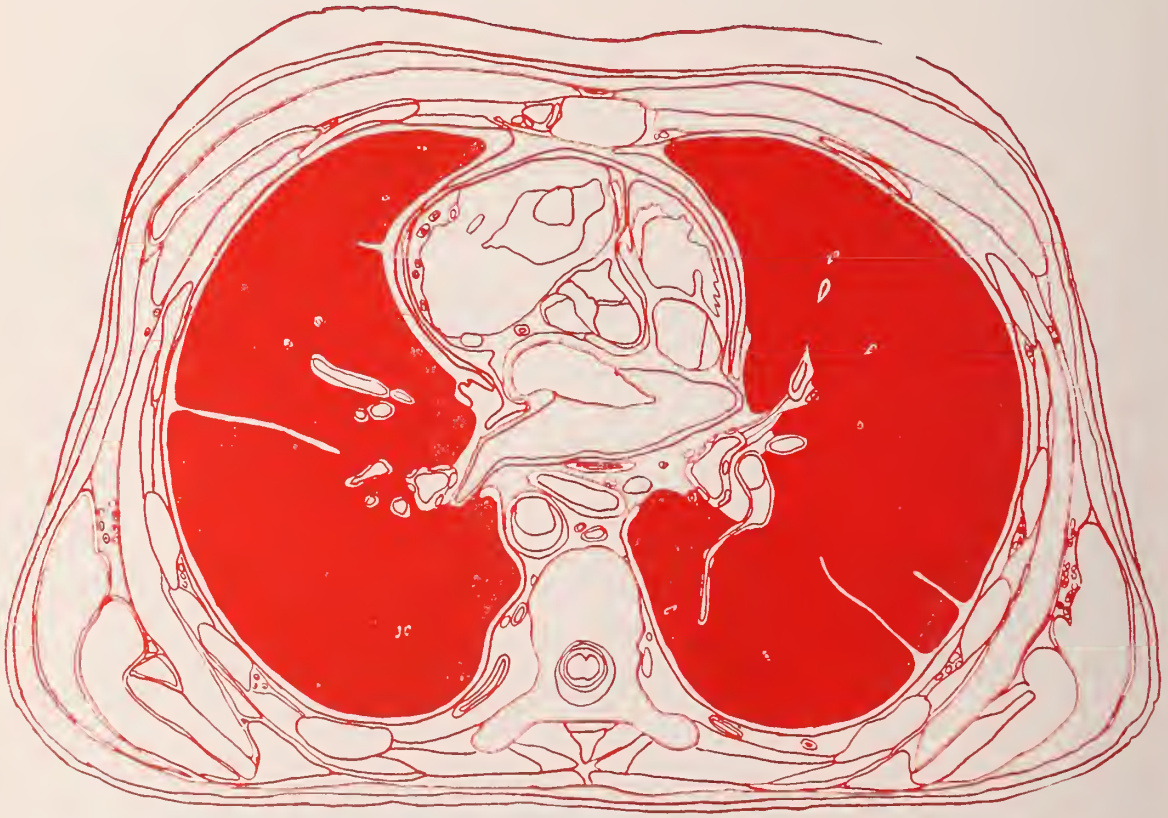
for bacterial pneumonias

Tetrex® capsules

The Original Tetracycline Phosphate Complex

U. S. PAT. NO. 2,791,609

effective control of pathogens...with an unsurpassed record of safety and tolerance



BRISTOL LABORATORIES, SYRACUSE, NEW YORK

BRISTOL™

SUPPLY: TETREX Capsules—tetracycline phosphate complex—each equivalent to 250 mg. tetracycline HCl activity. Bottles of 16 and 100.

TETREX Syrup—tetracycline (ammonium polyphosphate buffered) syrup—equivalent to 125 mg. tetracycline HCl activity per 5 ml. teaspoonful. Bottles of 2 fl. oz. and 1 pint.

Blood pressure that goes up with stress often comes down with SERPASIL®

(reserpine CIBA)

One reason that many cases of hypertension respond to Serpasil is that many cases are associated with stress. Stress situations produce stimuli which pass through the sympathetic nerves, constricting blood vessels, and increasing heart rate. Hyperactivity of the sympathetic nervous system may elevate blood pressure; if prolonged, this may produce frank hypertension. By blocking the flow of excessive stimuli to the sympathetic nervous system, Serpasil guards against stress-induced vasoconstriction, brings blood pressure down slowly and gently.

In mild to moderate hypertension, Serpasil is basic therapy, effective alone "... in about 70 per cent of cases ..."*

In severe hypertension, Serpasil is valuable as a primer. By adjusting the patient to the physiologic setting of lower pressure, it smooths the way for more potent antihypertensives.

In all grades of hypertension, Serpasil may be used as a background agent. By permitting lower dosage of more potent antihypertensives, Serpasil minimizes the incidence and severity of their side effects.

CIBA
SUMMIT, N. J.

*Coan, J. P., McAlpine, J. C., and Boone, J. A.: J. South Carolina M. A. 51:417 (Dec.) 1955. /2830M8

Complete information available on request.

In over five years

...for the tense and nervous patient

Despite the introduction in recent years of "new and different" tranquilizers, Miltown continues, quietly and steadfastly, to gain in acceptance. Meprobamate (Miltown) is prescribed by the medical profession more than any other tranquilizer in the world.

The reasons are not hard to find. Miltown is a ***known*** drug. Its few side effects have been fully reported. ***There are no surprises in store for either the patient or the physician.***

# of clinical use...

Proven
in more than 750 published clinical studies

Effective
for relief of anxiety and tension

Outstandingly Safe

1. simple dosage schedule produces rapid, reliable tranquilization without unpredictable excitation
2. no cumulative effects, thus no need for difficult dosage readjustments
3. does not produce ataxia, change in appetite or libido
4. does not produce depression, Parkinson-like symptoms, jaundice or agranulocytosis
5. does not impair mental efficiency or normal behavior

Miltown®

meprobamate (Wallace)

Usual dosage: One or two 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets; or as MEPROTABS*—400 mg. *unmarked,* coated tablets.

WALLACE LABORATORIES / *Cranbury, N. J.*

*TRADE-MARK

chronic leg ulcer?

"many patients who had ulcers from one to eight years obtained complete healing in six to ten weeks."[1,2]

CHLORESIUM®

ointment

CHLORESIUM Ointment has long been recognized as a medication of choice for local treatment of chronic wounds and ulcerations.[1,2] This time-tested agent is noted for its ability to promote healthy granulation, encourage normal epithelization, relieve pain and inflammation, and deodorize malodorous lesions. Furthermore, a complete lack of irritating or sensitizing properties makes CHLORESIUM ideal for patient-use at home.

CHLORESIUM Ointment—0.5% water-soluble chlorophyll derivatives in a hydrophilic ointment base, in 1-oz. and 4-oz. tubes.

CHLORESIUM Solution—0.2% water-soluble chlorophyll derivatives in isotonic saline solution, in 2-oz. and 8-oz. bottles.

(1) Boehme, E. J.: Lahey Clin. Bull. 4:242, 1946. (2) Diamond, O. K.: New York J. Med. **59**:1792, 1959.

Samples and literature available on request

Rystan Mount Vernon, N.Y.

34760

inner protection

Tain

(Triacetyloleandomycin, Triaminic® and Calurin®)

to contain the bacteria-prone cold

safe antibiosis

Triacetyloleandomycin, equivalent to oleandomycin 125 mg. This is the URI antibiotic, clinically effective against certain antibiotic-resistant organisms.

fast decongestion

Triaminic®, 25 mg., three active components stop running noses. Relief starts in minutes, lasts for hours.

well-tolerated analgesia

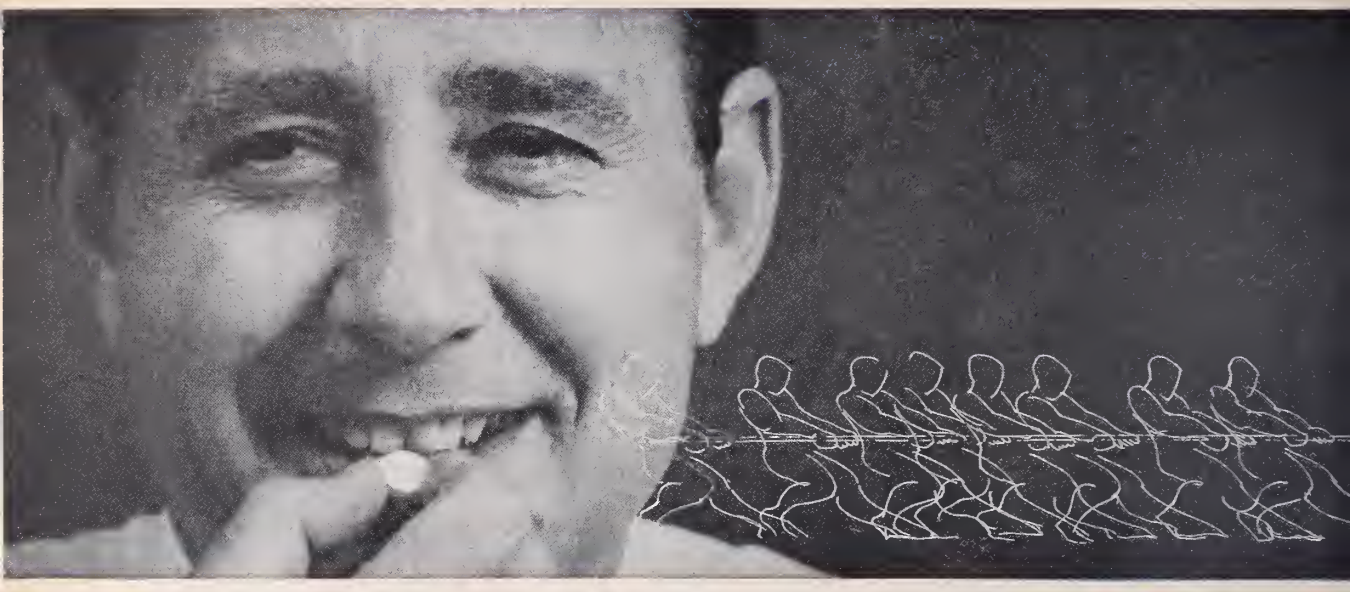
Calurin®, calcium acetylsalicylate carbamide equivalent to aspirin 300 mg. This is the freely-soluble calcium aspirin that minimizes local irritation, chemical erosion, gastric damage. High, fast blood levels.

TAIN brings quick, symptomatic relief of the common cold (malaise, headache, muscular cramps, aches and pains) especially when susceptible organisms are likely to cause secondary infection. Usual adult dose is 2 Inlay-Tabs, q.i.d. In bottles of 50. ℞ only. Remember, to contain the bacteria-prone cold...TAIN.

SMITH-DORSEY · LINCOLN, NEBRASKA

a division of The Wander Company

in antacid therapy...
patient cooperation is half the battle



Are you chancing unsatisfactory results because the patient doesn't like the taste of the antacid you have prescribed? Assure patient cooperation. Prescribe the antacid which assures patient acceptance through its excellent palatability.

Palatable

'Margel'

unsurpassed in performance
unequalled in palatability

antacid suspension/tablets

MARGEL is a highly palatable formulation of four antacids: selected aluminum hydroxides, magnesium hydroxide, magnesium trisilicate and calcium carbonate. Balanced to be non-constipating; formulated to be non-chalky. Write for a sample and see for yourself.

Supplied: Margel Suspension — bottles of 12 fluid ounces. Margel Tablets — boxes of 96.
Dosage: SUSPENSION: 1 tablespoonful 20 minutes after meals and on retiring. May be taken with milk if desired. TABLETS: 2 or more tablets 20 minutes after meals and on retiring. May be chewed or allowed to dissolve slowly in the mouth.

MRT *M.R. Thompson, Inc.* CRANFORD, N. J.

The physician listens to a tense, nervous patient discuss her emotional problems. To help her, he prescribes Meprospan® (400 mg.), the only continuous-release form of meprobamate.

The patient takes one Meprospan-400 capsule at breakfast. She has been suffering from recurring states of anxiety which have no organic etiology.

She stays calm while on Meprospan, even under the pressure of busy, crowded supermarket shopping. And she is not likely to experience any autonomic side reactions, sleepiness or other discomfort.

She takes another capsule of Meprospan-400 with her evening meal. She has enjoyed sustained tranquilization all day—and has had no between-dose letdowns. Now she can enjoy sustained tranquilization all through the night.

Relaxed, alert, attentive . . . she is able to listen carefully to P.T.A. proposals. For Meprospan does not affect either her mental or her physical efficiency.

Peacefully asleep . . . she rests, undisturbed by nervousness or tension. (Samples and literature on Meprospan available from Wallace Laboratories, Cranbury, N. J.)

WHEN ULCEROGENIC FACTORS KEEP ON WORKING...

REMEMBER THIS: SO DOES ENARAX

Think of your patient with peptic ulcer—or with gastrointestinal dysfunction—on a typical day.

Think of the anxieties, the tensions.

Think, too, of the night: the state of his stomach emptied of food.

Disturbing?

Then think of ENARAX. For ENARAX was formulated to help you control precisely this clinical picture. ENARAX provides oxyphencyclimine, the inherently long-acting anticholinergic (up to 9 hours of actual achlorhydria[1]) . . . plus Atarax, the tranquilizer that doesn't stimulate gastric secretion.

Thus, with b.i.d. dosage, you provide continuous antisecretory/antispasmodic action and safely alleviate anxiety . . . with these results: ENARAX has been proved effective in 92% of G.I. patients.[2-4]

When ulcerogenic factors seem to work against you, let ENARAX work for you.

ENARAX® B.I.D.

(10 MG. OXYPHENCYCLIMINE PLUS 25 MG. ATARAX®†) A SENTRY FOR THE G.I. TRACT

dosage: Begin with one-half tablet b.i.d.—preferably in the morning and before retiring. Increase dosage to one tablet b.i.d. if necessary, and adjust maintenance dose according to therapeutic response. Use with caution in patients with prostatic hypertrophy and only with ophthalmological supervision in glaucoma.

supplied: In bottles of 60 black-and-white scored tablets. Prescription only.

References: 1. Steigmann, F., et al.: Am. J. Gastroenterol. 33:109 (Jan.) 1960. 2. Hock, C. W.: to be published. 3. Leming, B. H., Jr.: Clin. Med. 6:423 (Mar.) 1959. 4. Data in Roerig Medical Department Files.

†brand of hydroxyzine

FOR HEMATOPOIETIC STIMULATION WHERE OCCULT BLEEDING IS PRESENT

HEPTUNA® PLUS

THE COMPLETE ANEMIA THERAPY

New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being™

Why diet is preferable to drugs

...in the control of serur

The objective of therapy is the approximation of the physiological norm.

This is most satisfactory when it can be accomplished by dietary manipulation. The control of elevated serum cholesterol through relatively simple changes in the dietary pattern of the patient puts nature's own processes to work most effectively to achieve the objectives of treatment.

The dietary approach does more than correct the serum cholesterol problem. Because overweight, together with improper eating patterns, is so often involved, the prescription of corrective diet helps the patient to help himself by establishing sound nutritional practices.

For the prophylaxis and prevention of hypercholestemia, the dietary approach affords the advantages of simplicity and economy. Diet therapy is for the long-term management of a chronic condition, while drug therapy is most efficient for acute situations.

The development of atherosclerosis is a slow process. It is believed that the onset of this condition is in early adulthood, but its clinical symptoms take as many as 20 years to manifest themselves. Simple changes in diet serve to keep the blood cholesterol concentration at an acceptable level.

Dietary therapy has other significant advantages over medication as follows:

1. Dietary adjustment involves little or no expense to the patient, whereas drugs are costly.
2. Dietary therapy may be made with complete safety—even for pregnant females.
3. Dietary therapy produces no side effects, whereas there is not as yet sufficient clinical evidence as to the long-term effects of drugs.
4. Dietary therapy brings about reduction in serum cholesterol through normal body processes, as yet not fully understood. On the other hand, some drugs can leave in the body accumulations of cholesterol precursors.
5. Dietary procedures do not usually generate new compounds in the blood which interfere with the chemical determination of blood serum cholesterol.
6. Dietary therapy offers a solution to the related problems of obesity which drugs do not.

Elevated serum cholesterol has long been linked to an imbalance in the ratio of the type of fat in the diet. Reductions in cholesterol levels have been achieved repeatedly, both in medical research and practice, through control of total calories and through replacement of an appreciable percentage of saturated fat by poly-unsaturated vegetable oil. An important measure in achieving replacement is the consistent use of poly-unsaturated pure vegetable oil in food preparation in place of saturated fat.

* * *

Poly-unsaturated Wesson is unsurpassed by any readily available brand, where a vegetable (salad) oil is medically recommended for a cholesterol depressant regimen.

ROCK CORNISH GAME HENS—Free Wesson recipes for delicious main dishes, desserts and salad dressings are ava able for your patients. Request quantity needed from The Wesson People, Dept. N, 210 Baronne St., New Orleans 12, L

More acceptable to patients. Wesson is preferred for its supreme delicacy of flavor, increasing the palatability of food without adding flavor of its own.

Uniformity you can depend on. Wesson has a poly-unsaturated content better than 50%. Only the lightest cottonseed oils of high iodine number are selected for Wesson, and no significant variations are permitted in the 22 exacting specifications required before bottling.

Economy. Wesson is consistently priced lower than the next largest seller.

Wesson's Important Constituents

Wesson is 100% cottonseed oil . . . winterized and of selected quality

Linoleic acid glycerides (poly-unsaturated)	50-55%
Oleic acid glycerides (mono-unsaturated)	16-20%
Total unsaturated	70-75%
Palmitic, stearic and myristic glycerides (saturated)	25-30%
Phytosterol (Predominantly beta sitosterol)	0.3-0.5%
Total tocopherols	0.09-0.12%

Never hydrogenated—completely salt free

holesterol

no irritating crystals[1] · uniform concentration in each drop[2]

STERILE OPHTHALMIC SOLUTION

NEO-HYDELTRASOL®

PREDNISOLONE 21-PHOSPHATE-NEOMYCIN SULFATE

2,000 TIMES MORE SOLUBLE THAN PREDNISOLONE OR HYDROCORTISONE

"The solution of prednisolone has the advantage over the suspension in that no crystalline residue is left in the patient's cul-de-sac or in his lashes . . . . The other advantage is that the patient does not have to shake the drops and is therefore sure of receiving a consistent dosage in each drop."[2]

1. Lippmann, O.: Arch. Ophth. **57**:339, March 1957.
2. Gordon, D.M.: Am. J. Ophth. **46**:740, November 1958.

supplied: 0.5% Sterile Ophthalmic Solution NEO-HYDELTRASOL (with neomycin sulfate) and 0.5% Sterile Ophthalmic Solution HYDELTRASOL®. In 5 cc. and 2.5 cc dropper vials. Also available as 0.25% Ophthalmic Ointment NEO-HYDELTRASOL (with neomycin sulfate) and 0.25% Ophthalmic Ointment HYDELTRASOL. In 3.5 Gm. tubes.

HYDELTRASOL and NEO-HYDELTRASOL are trademarks of Merck & Co., Inc.

MSD MERCK SHARP & DOHME Division of Merck & Co., Inc., Philadelphia 1, Pa.

SAUNDERS BOOKS

New (12th) Edition!—Thoroughly Revised and Up-to-Date

Greenhill—Obstetrics

This beautifully illustrated volume, in a completely revised edition, covers virtually every aspect of obstetrics *from nutritional counseling of the mother in early stages of pregnancy to pathology of the newborn.* Dr. Greenhill and his collaborators fully explain the mechanisms of labor plus step-by-step procedures in delivery. Effective care at every stage is detailed—immediate treatment of unexpected difficulties; prevention of accident and infection; relief of discomfort; management of various disease states concurrent with pregnancy. Complications and pitfalls are well outlined. The authors bring you fuller understanding of such topics as: *Antepartum Care—Toxemias of Pregnancy—Abortion—Multiple Pregnancy—Effects of Labor on the Child—Breech Extraction—Etc.*

From the Original Text by JOSEPH B. DELEE, M.D. By J. P. GREENHILL, M.D., Senior Attending Obstetrician and Gynecologist, The Michael Reese Hospital; Obstetrician and Gynecologist, Associate Staff, The Chicago Lying-In Hospital; Attending Gynecologist, Cook County Hospital; Professor of Gynecology, Cook County Graduate School of Medicine. With the Assistance of 23 Eminent Collaborators. 1098 pages, 7"x10", with 1219 illustrations on 903 figures, 119 in color. $17.00. *New (12th) Edition!*

A New Book!—Useful Techniques for Interpreting Chest Roentgenograms

Felson—Fundamentals of Chest Roentgenology

This practical text presents a clear introduction to x-ray diagnosis by demonstrating many useful techniques for interpreting chest films. It deals primarily with fundamentals and considers specific disease entities only for the purpose of illustrating the principles discussed. Many beautifully reproduced roentgenograms augment and illuminate the text discussions. An extensive series of films of normal chests shows minor deviations from the normal picture and explains which can be safely ignored. In addition, Dr. Felson includes a separate chapter on special roentgen signs which have important diagnostic implications. Here you will find *The Pulmonary Meniscus Sign, The Double Lesion Sign, The Notch Sign, The Butterfly Shadow, The Sail Shadow of the Thymus, etc.* The principles outlined here can be effectively applied to evaluation of films of other body areas.

By BENJAMIN FELSON, M.D., Professor and Director, Department of Radiology, University of Cincinnati College of Medicine; Director, Department of Radiology, Cincinnati General, Children's, Daniel Drake, Dunham, Christian R. Holmes, and Longview Hospitals; Special Consultant, U. S. Public Health Service; Consultant to the Dayton and Cincinnati Veterans Administration Hospitals. 301 pages, 6½"x10", with 450 illustrations on 238 figures. About $11.00. *New—Just Ready!*

A New Book!—Management of Today's Industrial Accidents and Hazards

Johnstone & Miller—Occupational Diseases & Industrial Medicine

With increased exposure of the public to toxic materials, more physicians are confronted with situations closely related to the practice of industrial medicine. This useful volume compiles all the known information about occupational disorders—*their prevention, diagnosis and management.* The authors illuminate the full spectrum of the field from *Scope and Elements of Industrial Medical Practice* to *Diagnosis of Occupational Diseases.* The major part of the book is devoted to clear, concise descriptions of the occupational diseases, utilizing the clinical approach throughout. Organization logically progresses from etiology, signs and symptoms, treatment, estimation of permanent and temporary disability. Treatment is well outlined. Among the injurious agents covered, you'll find *Noxious Gases, Resins and Plastics, Pesticides, Ionizing Radiations, etc.*

By RUTHERFORD T. JOHNSTONE, M. D., Consultant in Industrial Medicine, Clinical Professor of Preventive Medicine and Public Health and Clinical Professor of Medicine, University of California at Los Angeles; and SEWARD E. MILLER, M.D., Director, Institute of Industrial Health, Professor of Medicine, Medical School, Professor of Industrial Health, School of Public Health, University of Michigan, Ann Arbor. 482 pages, 6¼"x9¾", illustrated. About $11.50. *New—Just Ready!*

Order Today from **W. B. SAUNDERS COMPANY**
West Washington Square Philadelphia 5

Saunders books

SJG-10-60

Please send and charge my account:
- ☐ Greenhill's Obstetrics, $17.00.
- ☐ Felson's Fundamentals of Chest Roentgenology, about $11.00.
- ☐ Johnstone & Miller's Occupational Diseases and Industrial Medicine, about $11.50.

Name_____

Address_____

Squibb Announces Chemipen

Squibb Alpha-Phenoxyethyl Penicillin Potassium

new chemically improved penicillin which provides the highest blood levels that are obtainable with oral penicillin therapy

As a pioneer and leader in penicillin therapy for more than a decade, Squibb is pleased to make Chemipen, a new chemically improved oral penicillin, available for clinical use.

With Chemipen it becomes possible as well as convenient for the physician to achieve and maintain higher blood levels—with greater speed—than those produced with comparable therapeutic doses of potassium penicillin V. In fact, Chemipen is shown to have a 2:1 superiority in producing peak blood levels over potassium penicillin V.*

Extreme solubility may contribute to the higher blood levels that are so notable with Chemipen.* Equally notable is the remarkable resistance to acid decomposition (Chemipen is stable at 37°C. at pH 2 to pH 3), which in turn makes possible the convenience of oral treatment.

And the economy for your patients will be of particular interest—Chemipen costs no more than comparable penicillin V preparations.

Dosage: Doses of 125 mg. (200,000 u.) or 250 mg. (400,000 u.), t.i.d., depending on the severity of the infection. The usual precautions must be carefully observed with Chemipen, as with all penicillins. Detailed information is available on request from the Professional Service Department.

Supply: Chemipen Tablets of 125 mg. (200,000 u.) and 250 mg. (400,000 u.), bottles of 24 tablets. Chemipen Syrup (cherry-mint flavored, nonalcoholic), 125 mg. per 5 cc., 60 cc. bottles.

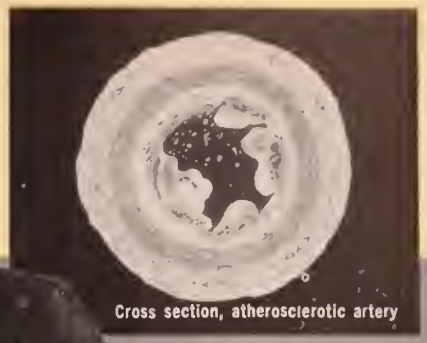
*Knudsen, E. T., and Rolinson, G. N.: Lancet 2:1105 (Dec. 19) 1959.

"CHEMIPEN" IS A SQUIBB TRADEMARK.

SQUIBB

Squibb Quality—the Priceless Ingredient

outstanding nutritional research achievement


Cross section, atherosclerotic artery

to aid in the dietary control of serum cholesterol

MAZOLA®

MARGARINE
scientifically formulated with pure liquid non-hydrogenated MAZOLA Corn Oil.

MAZOLA Margarine is an economical tablespread and serves as a solid shortening, rich in linoleic acid and low in the more saturated fatty acids — making it an ideal dietary adjunct in the management of serum cholesterol. It contains 2 to 3 times as much linoleic acid as any other margarine in the grocery store, and 5 to 8 times as much as butter. It contains no dairy or animal fats, no coconut oil, and no cholesterol.

MAZOLA Margarine is indistinguishable from other quality margarines as to taste, aroma and handling characteristics. Thus, it can be part of the regular diet for the whole family, including the hypercholesterolemic patient. The major ingredient in MAZOLA Margarine — liquid MAZOLA Corn Oil—is NOT hydrogenated, thereby preserving its rich content of linoleates.

Two ounces or 56.8 Gm. (4 tablespoons) of MAZOLA Margarine supply:

Linoleic acid	12 Gm.
Oleic acid	23 Gm.
Saturated fatty acids	8 Gm.
Plant sterols (sitosterols)	215 mg.
Natural tocopherols	30 mg.
Vitamin A	1870 USP units
Vitamin D	250 USP units
Calories	415

Available in the refrigerator sections of grocery stores in the same general price range as other premium quality margarines, in 1-lb. packages (four ¼ lb. sticks).

Send for free booklet:
"Recent Advances in the Dietary Control of Hypercholesterolemia."

BEST FOODS • Division of Corn Products Co., NEW YORK 22, N. Y.

hearing improved...

tinnitus
and vertigo
relieved in
circulatory disturbances
of the inner ear[1]

arlidin®

brand of nylidrin
hydrochloride N.N.D.

effective in twice as many patients

In patients with disturbances of the inner ear—impaired hearing, tinnitus or vertigo—Arlidin produced remission of their chief complaint in over 50% of cases. Rubin and Anderson state "we were very much encouraged, inasmuch as no other vasodilator that we have used has ever achieved more than a 25 per cent response."

"significant hearing improvement"

was obtained in 32 of the 75 patients studied.

rationale: The clinicians note that impairment in hearing, disturbance in balance, and tinnitus involving the inner ear "may be explained on the basis of labyrinthine artery insufficiency" due to spasm or obstruction of the vessels. Arlidin was found to be "superior to all other vasodilating measures" in increasing blood flow through these vessels and in allaying spasm.

Arlidin is available in 6 mg. scored tablets, and 5 mg. per cc. parenteral solution. See PDR for dosage and packaging.

Protected by U. S. Patent Numbers: 2,661,372 and 2,661,373

1. Rubin, W., and Anderson, J. R.: Angiology 9:256, 1958.

u. s. vitamin & pharmaceutical corporation

Arlington-Funk Labs., division • 250 East 43rd Street, New York 17, N. Y.

...“superior to all other vasodilating measures in its effect on the labyrinthine arteries.”

...efficacious where other vasodilators failed

aid to hearing in tablet form

arlidin

FOR THE ANXIETY TENSION PATIENT WHO IS ABOUT TO

Effective Anticholinergic-Antitensive

Relaxes the Spastic G. I. Tract

SED-TENS

TY-MED*

A unique timed-release principle incorporating the delayed acting therapeutic ingredients in an inert tablet matrix.

The release of medication is an erosive mechanical process independent of chemical media, therefore, not effected by gastro-intestinal environment.

DOSAGE: One tablet morning and night.

Each Ty-Med* tablet contains:

Amobarbital . . . . . 50 mg.
Homatropine Methylbromide 7.5 mg.

*LEMMON brand of timed-release medication.

A clinical supply of SED-TENS Ty-Med tablets is available from . . .

LEMMON PHARMACAL CO

Sellersville, Pa.

LEMMON PHARMACAL COMPANY

in infectious disease[17,22,30]
in arthritis[18,19,20]
in hepatic disease[2,3,4,5]
in malabsorption syndrome[1,2,6]
in degenerative disease[6,7,19,20]
in cardiac disease[23,28,29,38]
in dermatitis[24]
in peptic ulcer[8,21]
in neuroses & psychiatric disorders[25]
in diabetes mellitus[31,32,33]
in alcoholism[9,11,35,37]
in ulcerative colitis[10,14,
in osteoporosis[13,19,
in pancreatitis
in female climacteric[12,

Patients with chronic disease deserv
the nutritional support provided b

Theragran-M

Squibb Vitamin-Minerals for Thera

11 vitamins, 8 mineral
clinically-formulated and potenc
protected to provid
enough nutritional suppo
to do some goo

with vitamins on

Theragra

also availabl

Theragran Liqui
Theragran Junio

Theragran products do not contain folic

1-41 a list of the above references will be supplied on re

SQUIBB

Squibb Quality—the Priceless Ingre

"THERAGRAN" IS A SQUIBB TRADEMARK

when she's not like herself anymore

Metalex® basic in the care of the aging

when body tone, mental and sensory faculties begin to fade—*she's irritable, confused, forgetful, apathetic*

when voices begin to fade—*in loss of auditory acuity, in tinnitus*

when vision begins to dim—*in loss of visual acuity, in loss of peripheral vision*

℞ Metalex® *cerebral stimulant / vasodilator*

The stimulant—pentylenetetrazol—facilitates cerebral and reflex nerve activity.

The vasodilator—nicotinic acid—augments blood and oxygen supply to vital areas—

Thus, METALEX increases body tone and aids mental and sensory faculties.

Composition: Each teaspoonful (5 ml.) of the Elixir and each Tablet contains: Pentylenetetrazol 100 mg., Nicotinic Acid 50 mg.

Dosage: One or two teaspoonfuls of the Elixir or one or two Tablets four times a day—one-half hour before meals and before bedtime.

Available: Elixir: Pint and Gallon bottles. Tablets: Bottles of 100 and 1000.

References: 1. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics, 2nd Ed., New York, Macmillan Company, 1955. 2. O'Reilly, P. O., Demay, M. and Kotlowski, K.: Cholesteremia and Nicotinic Acid. A.M.A. Arch. Int. Med. 100:797-801 (Nov.) 1957.

STORCK Pharmaceuticals, Inc.,
2326 Hampton Blvd., St. Louis 10, Mo.

NEW PROFESSIONAL LIABILITY INSURANCE PROGRAM APPROVED BY YOUR MEDICAL SOCIETY

American Mutual has been appointed by the 1960 House of Delegates of The Medical Society of New Jersey to provide your professional liability insurance. (See article in August JOURNAL, page 497.)

This means protection by the *first* American liability insurance company. Long experience in the field of professional liability insurance has led to a practical solution of one of the important problems—that of *loss control*—faced by the medical profession.

Insurance for Professional Liability and Professional Premises Liability is available to members of The Medical Society of New Jersey. Professional Liability Insurance is also available to the registered nurses and qualified technicians employed by our policyholder doctors.

Protection for Libel, Slander and Defamation of Character arising out of activities on committees of State and County Medical Societies and committees of licensed hospitals is furnished to all insured doctors.

Please address your request for further information about this program to:

American Mutual Liability Insurance Company

PROFESSIONAL LIABILITY DEPARTMENT

68 SOUTH HARRISON STREET EAST ORANGE, NEW JERSEY

JOSEPH A. BRITTON, Manager ORANGE 3-2575

HOME OFFICE: WAKEFIELD, MASS.

. . . DARVO-TRAN™ relieves pain more effectively than the analgesic components alone

Effective analgesia *plus* safe relief of mild anxiety helps combat the pain-anxiety spiral. In Darvo-Tran, the tranquilizing properties of Ultran® are added to the established analgesic effects of Darvon® and the anti-inflammatory benefits of A.S.A.®. Clinical and pharmacologic studies have shown that when pain is accompanied by anxiety, the addition of Ultran *enhances* and *prolongs* the analgesic effects of Darvon.

Lilly

Each Pulvule® Darvo-Tran provides:

Darvon	32 mg.	TO RAISE PAIN THRESHOLD
A.S.A..	325 mg.	TO REDUCE INFLAMMATION
Ultran.	150 mg.	TO RELIEVE ANXIETY

Usual Dosage:
1 or 2 Pulvules three or four times daily.

Darvo-Tran™ (dextro propoxyphene and acetylsalicylic acid with phenaglycodol, Lilly)
Ultran® (phenaglycodol, Lilly)
Darvon® (dextro propoxyphene hydrochloride, Lilly)
A.S.A.® (acetylsalicylic acid, Lilly)

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U. S. A.

020407

THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

Diabetes Detection Week

The ever-growing diabetic population of this country (which has now reached 3½ million) poses a challenge to the physician. The challenge once was how to save the patient's life. Happily, this phase of therapy is well in hand. Diabetic deaths are usually due to carelessness on the part of the patient. The task before us now is the proper management of the growing and youthful diabetic. Forty years ago, a diabetic child would never have reached the age of ten. Today young diabetics fill the hospital beds with peripheral vascular and eye complications. The dreaded complications can be delayed by proper management of diabetes. These patients *can* have a more useful life and need not become a burden to their families and the community.

Each year, in November, the American Diabetes Association promotes an educational campaign for the benefit of the population-at-large. The goal is to ferret out the early, unrecognized diabetic. Last year, during Diabetes Detection Week in New Jersey, 16,821 persons were tested (9053 urine and 7768 blood specimens were examined); 73 new diabetics were discovered and referred to the family physician for proper care.

The 1960 drive should be only a reminder that the process of diabetes detection must be a year-round job. Only in this way can the up-hill fight be led successfully.

Diabetes Detection Week starts on November 13, 1960. Physicians should see this as an opportunity to reassert medical leadership in this literally life-saving and disability-preventing campaign.

PUBLISHED MONTHLY SINCE 1904
Under the direction of the Committee on Publication
FRED B. ROGERS, M.D., *Chairman*

HENRY A. DAVIDSON, M.D., *Editor*
MIRIAM N. ARMSTRONG, *Assistant Editor*

Place of Publication, Printing and Mailing—116 Lincoln Avenue, Orange, N. J.
Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.
Send all communications for publication to P.O. Box 904, Trenton 5, N. J. — Telephone EXport 4-3154
Each paying member of the State Society is entitled to receive a copy of THE JOURNAL every month
Whole Number of Issues 674

VOL. 57, NO. 10 OCTOBER, 1960 Subscriptions, $3.00 per Year Single Copies, 30 Cents

Blue Shield as a Whipping Boy

Like a somewhat wayward child, Blue Shield often plays the role of favorite whipping boy for the doctors who created it. Wherever several physicians are gathered together—in staff room or on the second tee—someone is certain to take out after the Blue Shield Plan.

When the definitive history of prepayment is written, perhaps one may trace a falling rate of divorce among physicians who have worked out so many of their frustrations, not on their wives, but on their Blue Shield Plans.

Some Blue Shield administrators confess to a wry satisfaction in all this—recognizing that a parent is always fussier with his own offspring than with a child for whom he has no emotional affinity.

Blue Shield is a vast community umbrella designed to ward off the rain of medical adversity which falleth alike upon the just and the unjust. It serves the need of the average man as best it may, but it sometimes falls short of the special needs or wishes of the individual patient and his doctor.

In these parlous times, when the Forand philosophy seems to have so thoroughly infected the politicians of both parties, American medicine has reasons more apparent than ever before to honor those medical pioneers who built Blue Shield, and to support the civic and professional leaders who today are working so hard to make Blue Shield an ever more effective instrument.

Without the reality of a strong and growing Blue Shield movement during the 1950's America would long since have had universal compulsory health insurance. If American medicine escapes the thralldom of bureaucracy during the 60's, it will have the voluntary prepayment movement—chiefly Blue Shield—to thank for its good fortune.

Let's all keep a closer eye on Blue Shield—not merely to discern the motes in its eye—but to encourage it to do the best job it can do for us and for the American people.

Out of the Rut

Most of us are too busy these days. Just keeping up with the medical literature alone could be a full-time job. Not to mention going to county medical meetings, hospital staff sessions and specialty societies; and examining patients, listening to detail men, going to court, making calls, participating in hospital rounds (and sometimes doing a stint in the emergency room). And, lest we forget, treating patients.

It's good to be busy, but it is bad to be narrow. As we work faster and harder we scoop out the rut; it becomes narrower as well as deeper. Hence the well-meant but seldom practiced advice: get a hobby; go fishing; take up golf, stamp collecting or pigeon breeding.

Some doctors have avoided the danger of narrowness by going into nonmedical fields: not as a dilettante, but as an expert. Some, indeed, have achieved fame in those areas. The muse of authorship knows us: A. J. Cronin and Somerset Maugham; Rabelais and Albert Schweitzer (strange ones to pair!), Tobias Smollett and Sir Thomas Browne. Our poets include Oliver Goldsmith and Merrill Moore and our famous Jerseyite, William Carlos Williams. There was a well-known M.D. botanist (R. J. Thornton). Did you know that John Keats was a physician? (Guy's Hospital, 1816).

So was the explorer Elisha Kent Kane; and the architect Claude Perrault. We salute, too, our own H. Ameroy Hartwell, a man of many parts. Oddly—or maybe naturally — several well-known mountaineers were physicians: Charles Houston, I. T. Talbot, Clifton Dent, William Howard and Jeremiah Van Rens-

selacr. We are not likely to flourish as athletes—at least not after age 30. Roger Bannister,* though, was an M.D.

You can make your own list. The point is that these delightful truants from medicine made solid contributions to the world; and had a good time doing it.

Perhaps we carry with us too much the odor of the sick-room and the tools and papers of our profession. There is no point in laboring the need for diversion and relaxation. That's obvious. One can find this diversion at any age. Sometimes, indeed, senority brings it with the time to delve into life's literary and cultural sidelines. But this we know: a happy man needs breadth of interest. Medicine is not only a jealous mistress but, if you let her, a restricting one too. A diversion into some other field seems indicated. Besides—with early retirement and more old age benefits being promised by all candidates, it might be well to have an interesting activity for retirement. You never can tell.

*The 4-minute-mile man.

Executive Health: A New Medical Specialty

Industry's concern over mounting personnel losses due to death and illness is creating a new specialty. Medical experts in the field of executive health, while few in number, are becoming a vital part of an effort by American industry to improve the health of management personnel. Keeping executives healthy through regular medical surveys, answers one of management's most vexing problems.

Dr. Richard E. Winter, Executive Director of New York Executive Health Examiners, agrees that this field is in its infancy. Many medical groups examine executives, but actually few specialize in the field. Well known units, such as the Mayo Clinic, the Crile Clinic, Pratt Diagnostic Center and Lahey Clinic, examine many executives; but usually with a specific objective or following a definite complaint which brings the man in. New York Executive Health Examiners and the Montclair Executive Health Center in our own state are typical of the units that look for "anything" in a series of carefully planned examinations and tests.

Management is following the first rule of preventive medicine by sponsoring (at its own expense) these periodic and thorough health surveys. The early detection and prompt treatment of glaucoma, gastro-intestinal disturbances, cardiac and proctologic disorders, as well as emotional, social and economic problems prove, in most cases, that disability can be prevented or controlled if deviations are discovered in time. Stress situations on the job or in the home are danger points that thus can be explored and corrected.

Periodic examinations relieve worry, reassure the executive on health matters, provide a basis for comparison in yearly analysis and, perhaps most important, provide a basis for personal health education. Conscientious labor organizations have long made medical coverage a "fringe benefit" demand. It seems odd that management had waited so long to develop corresponding benefits for executives.

In a highly competitive executive market, loss of key personnel through death or illness, or replacement is an expensive time-consuming and disturbing process. The growth of Executive Health Centers and their use by American industry minimizes personnel loss, educates the executive to improved health care and health planning measures, which promptly reflect in improved business efficiency. Industry's concern for executive health is not only creating a new field of specialization, but might well point the way to a new era of preventive health care for all the American people.

Industry seems to be taking the initiative here. Perhaps medicine should exercise leadership in this field—rather than let the initiative pass into other hands.

—RBM

Original Articles • • •

MORRIS PARMET, M.D.

Flemington

The Role of the Full-Time Psychiatrist in the General Hospital*

Psychiatry is often thought of as an urban or suburban luxury. But, as Dr. Parmet here shows, there is a place for it in rural areas too. We are here given a description of how this specialty can function in a small, rural general hospital.

THE full-time psychiatrist in a general hospital has the opportunity to offer creative leadership in many areas. Just how he may fulfill his role depends on the setting, the aims and objectives of the Board of Trustees, on the character of medical practice in the area, the goals and desires of close professional co-workers, on the personality of the individual psychiatrist, his areas of interest, and the time available to do the professional job. Allowing for variations in background, orientation, and training, it is highly probable that, without clearly defined objectives, individual psychiatrists would set up programs differing considerably in emphasis.

However, just as the psychiatrist has a role to fulfill, so does the general hospital have certain expectations placed upon it which, in turn, are directed to the psychiatric staff. A committee of the New Jersey Neuropsychiatric Association stated in October, 1956, that "No hospital is entitled to the honorable adjective 'general' if it rejects the commonest type of illness in the world."[1] General hospitals are accepting this principle, but face staffing shortages. Admission of the psychiatric patient is often a temporary expedient, or a means of treating an acute short-term problem; or as an emergency measure, as part of an evaluative procedure prior to some other disposition; or, with the returning patient, in providing leadership and direction in rehabilitation and resocialization. Yet the psychiatrist has many other opportunities for using his skills, particularly in the area of prevention. In our setting these may include the nursery, studies of the parental relationship to the sick child, rooming-in on the maternity floor, and an expanding geriatric program. With hospitals reaching beyond their doors and becoming more vital participants in community mental health, the psychiatrist carries some of the functions of the public health official. Add to this teaching, consultation, in-service training of hospital nurses, public health nurses, house staff, and other professional personnel and the psychiatrist's influence can be widespread indeed.

I draw my material from a highly selective program now seven years old. Hunterdon Medical Center, outside of Flemington, New Jersey, serves a rural population of 46,000. The program is well described in a book entitled, *Hunterdon Medical Center*.[2] Its author,

*Read at Atlantic City, May 17, 1960, before the Neuropsychiatry Section of The Medical Society of New Jersey at its Annual Meeting.

1. Davidson, H. A. and Loeser, L. H.: Special Report on General Hospitals, submitted October 1, 1956 to the New Jersey Neuropsychiatric Ass'n.

Dr. Ray E. Trussell was the first medical director of the Hunterdon Medical Center. In an early memorandum Dr. Trussell stated that the "Hunterdon Medical Center was conceived, designed, equipped, organized, staffed, and opened as a focal point of county-wide health work—not limited to the sick or to the walls of the building." In his book, Dr. Trussell adds, "There were two basic aims: the Center was to be more than a hospital and the mental health program was to be more than a clinic. This removal of traditional walls offered the staff and the community an opportunity to develop working relationships without total precedent."[2] The integration of mental health gave support to professional activities. However, the areas delineated and the direction of emphasis were a direct outgrowth of the thinking of the mental health team with leadership and direction from the psychiatrist.

PREVENTION, early detection, treatment, and rehabilitation were objectives in planning for the entire population—county and hospital. A guiding principle that determined many of our activities was to see how effectively the skills of each individual specialist could be utilized in a manner to serve best the broader interests of the hospital and the community. This "optimum utilization" served as a check for indulging too exclusively in any special interest we might hold. My own special interest was child psychiatry; but, in making psychiatric consultation and treatment available for both children and adults, more adults requested help than did parents seeking help for children, much to my surprise. I learned that a large reservoir of mental illness existed in our rolling hills, despite some local implications that sunshine, fresh air, healthy recreation, and the absence of urban slums would minimize the incidence of mental illness. I was sure that if services were generally made available at fees that patients could afford, utilization would be more widespread; or, at least, we would know the level of readiness to accept services.

The Medical Center Staff was composed of the local general practitioners plus a full-time specialist staff. The specialist carried responsibility for direction and supervision of his service and for maintaining high medical standards of performance. He was expected to work with, supplement, and support the role of the general practitioner and not compete with him. All members of the full-time staff held teaching appointments at New York University School of Medicine. This served as a basis for elevating standards of medical care and for providing day-to-day graduate medical education for the general practitioner. Learning is accomplished best in informal ways, such as curbside consultation, joint management of patients, and through participation in patient care on other services. This same concept forms the core of modern day teaching of psychiatry in medical schools and has been the basis of the teaching program at Hunterdon Medical Center.

Participation in other services has also affected the structure of the Psychiatric Department. Psychiatry functions more effectively and provides a more constructive influence when it is not segregated physically and functionally, but rather when it related itself to the many psychological needs within the framework of other existing departments. A roving psychiatrist found many opportunities to carry on informal discussions with nurses, family doctors, other specialists, patients and their families, and house staff. Informal discussions led at times to more formal and planned meetings. This particular practice has been carried out with the nurses for several years. Early morning coffee beginning with chit-chat led into discussions of some current patients; and, out of this, evolved subjects leading into special conferences. A few examples will be helpful.

THE nurses asked for round tables on better understanding of the coronary patient, the asthmatic patient, and the patient with ulcerative colitis. They manifest special interest in the patient who incessantly complains but for

2. Trussell, R. E.: *Hunterdon Medical Center.* Cambridge 1956. Harvard University Press.

whom only negative physical findings exist. They were having trouble caring for these patients and they sought a better understanding of their own irritability and hostility which sharply interfered with their nursing functions. The significance of supervision frequently came up. In an earlier paper,[3] I noted that "the entire process of supervision is concerned with the basic problem of taking help . . . The role of the supervisor is indeed a delicate one and the task of recognizing and understanding the attitudes that confront her is formidable." The psychiatrist, while helping to clarify these attitudes, gave support to and reinforced the role of the supervisory nurse and indirectly contributed to improved patient care.

The family doctor was seen as the central core of the program, providing continuity of service, which is the keystone of all good medical care. When the psychiatrist recognizes that he can by himself treat only a small proportion of the mentally ill, he can broaden the treatment potential in his community by maintaining a close collaborative relationship with the family physician. Through this he can help the family physician in making better referrals; in helping to define a pattern of care which the family physician can execute, in carrying some cases jointly, and in providing seminars which enhance the individual physician's understanding of psychological mechanisms and the dynamics of interpersonal relationships. Physicians, nurses, lawyers, ministers, and others carry out counselling in the fulfillment of their duties. We have arranged several series on marriage counselling for this group; not to make them into skilled marriage counsellors, but to give them a better understanding of what they were already doing. These activities extend the scope of care of the mentally and the emotionally ill. As Garber[4] has said: "We should take a renewed and strenuous interest in offering of undergraduate and graduate courses to all interested non-psychiatrists—We should develop greater participation in county medical society meetings and in general hospital staff meetings. We must become aware of the absolute necessity of increasing methods of communication so that the referring physician has some knowledge of the treatment program undertaken. We need to become more commonly known as members of a general hospital staff, allotment of time for in-patient and out-patient consultations, opportunities to be seen and observed in hospital corridors so as to promote a better flow of communication with our non-psychiatric colleagues." The essential definition of professional relationships in Hunterdon Medical Center has permitted carrying out this advice.

FURTHER effects of not segregating the psychiatric team physically and functionally were seen in the relationship of the Pediatric and Medical Departments. The close working with the Pediatric Department has been discussed in a previous paper.[5] "It was felt that child psychiatry and pediatrics should seek continuously to find within the framework of their program new and better ways for collaboration. To this end a conference evolved that would deal primarily and specifically with emotional problems." This conference has served as a training seminar pointing up emotional factors in illness, studies in family interaction, and gave us an opportunity to observe supportive and destructive factors operative in the local community. This combined conference jointly initiated by the pediatrician and the psychiatrist has been running for five years and has extended participation to include nurses, family doctors, residents, interns, medical students, social workers, psychologist, speech therapist, judge, probation officer, occupational therapist, physical therapist, public health nurses, school guidance personnel and others. The pediatric conference has given added recognition to the principle that these key people in the com-

3. Parmet, M.: American Journal of Nursing, 57:329 (March, 1957).

4. Garber R.: Journal of the Kentucky Medical Association, February 1960. Volume and page not given.

5. Parmet, M.: Paper on "Interdisciplinary Organization Around the Pediatric Patients." Transactions of the March 1958 session of the American Orthopsychiatric Association.

munity must be given support to do a better job in prevention and to carry many "treatment" functions although the psychiatrist is still available to carry treatment responsibility for those situations which cannot be handled by the less skilled resource.

The Child Guidance team participates in a regular monthly conference with school and court personnel around hard core problems in the schools and community. The mental health team participates in programming for all ages with meetings and seminars being held on developmental problems, delinquency, strengthening family life, and problems of aging.

Treatment of psychiatric in-patients has been described in an earlier paper.[6] It was learned that many psychiatric patients could be cared for adequately in our setting and make a smooth and easy transition to continuing out-patient care without suffering any break in the continuity of care. This has been accomplished on the open medical floor and on other open services throughout the hospital. The ready availability of the family to participate in the treatment process and the continuing relationship of the family physician to the patient were significant factors in promoting recovery. It is apparent that such procedure has important values educationally in getting across a better understanding of mental illness and the excellent prospects of recovery where treatment can be family centered. This is possible where treatment can occur close to home in a setting acceptable to the patient and his family. One looks to the psychiatrist to encourage and recommend an extension of such services.

Whether the patient receives his psychiatric care in a community hospital or elsewhere, it is desirable that after-care needs be met in the local community. This is an area that should receive the support and encouragement of a full-time psychiatrist, whether he functions full time in a community hospital or in the community. The psychiatrist functioning in a community hospital sits in a strategic position which sharpens his awareness of the wide pattern of psychiatric need. Some of the services he himself may provide; but, whether he provides them or not, he must encourage their development. These include day care and night care programs, half-way houses, sheltered work shops, residential care units, and ultimately a logical extension of the hospital program to a home care program. The psychiatrist, in joint planning with the medical staff, can help in the development of facilities which, though good for psychiatric patient care, can serve other areas of the hospital community also, such as the aging, and the chronically ill.

The psychiatrist functioning full time in the community general hospital becomes the general practitioner of mental health. He fulfills many varied roles. Because of the difficulty in functioning effectively on so many fronts, it would seem better if this could be accomplished by a staff of psychiatrists so that each would be freer to develop his own area of special interest. However, lacking numerical adequacy of mental health personnel, it would seem that the plan undertaken in Hunterdon County fits the needs of the rural medical center. It is conceivable that some urban centers equally lacking in skilled personnel could use a similar plan advantageously.

---

6. Pellegrino, E. and Parmet, M.: Paper on "The Treatment of Psychiatric Patients on Open Medical Floors." Presented May, 1960 at the American Psychiatric Association Annual Meeting in Atlantic City.

Hunterdon Medical Center

EDMOND EDELSON, M.D.

Newark

Syphilis Today*

The resurgence of syphilis is one of the dramatic facts of mid-century medicine. Here is one compact monograph, Dr. Edelson presents diagnostic technics and management methods in clear, over-the-counter fashion.

For most of the penicillin era, physicians have regularly predicted an upsurge in the number of newly discovered syphilitics. This was because the penicillin in doses used for the treatment of gonorrhea had been inadequate to cure any concomitantly incubating syphilitic infection, thus only *suppressing* the signs of early syphilis. This allowed the disease to develop into one of its later stages before being detected. It has come as a shocking surprise, therefore, to discover that the past several years have produced instead, an auspicious *increase* in the rate of *early* infectious syphilis.

This paper reviews syphilis as we see and manage it today in a large industrial city. Similar communities have been reporting comparable statistics. Smaller communities have also found that infectious syphilis is increasing, although to a lesser extent.

Table No. 1 illustrates the consecutive rise of early syphilis during the past three years in Newark. Our figures for the first four months of 1960 indicate that this year, too, is showing a further increase in the rate of early syphilis.

The progressive rise of the total for each of the stages is readily seen, and particularly impressive is each year's total. Thus, 1958 with 203 patients with early syphilis represents a 46 per cent increase over 1957. And 1959 with 364 early syphilitics is a 79 per cent rise over 1958 and more than two and one-half times the 1957 rate. The national trend simulates this pattern. The total early infectious syphilis increased throughout the United States from 6,651 patients in 1958 to 8,178 in 1959, a rise of 23 per cent. For the first quarter of fiscal 1960, the country reports a 42 per cent increase in infectious syphilis over the corresponding 1958 quarter. On the basis of the customary high proportion of unreported patients, the aforementioned 8,178 cases of reported infectious syphilis represent the actual occurrence of about 60,000 such cases. In addition, 237,000 patients with gonorrhea were reported out of an estimated total of a million infected individuals. This means that many syphilitic infections combined with this gonorrhea went unrecognized. We can only hope that the therapy for the gonorrhea was also adequate to cure the incubating cases of syphilis.

Table 2 shows the total number of new syphilitics from our clinic alone. All our cases are reported. These figures represent the largest segment of Newark's syphilis and give a clear picture of the problem as it faces many similar cities. There was a 94 per cent rise in the number of early syphilitics in 1958 over 1957; and a 56 per cent increase in 1959 over

*This work is from the Department of Health, Newark, N. J. This paper was read at Atlantic City, May 17, 1960, before the Dermatology Section at the Annual Meeting of The Medical Society of New Jersey.

TABLE I - NEWARK, NEW JERSEY - EARLY SYPHILIS

	COLOR & SEX		1957 PRIM.	1957 SEC.	1957 E.L.	1958 PRIM	1958 SEC.	1958 E.L	1959 PRIM	1959 SEC	1959 E L
NEWARK V.D. CLINIC	WHITE	MALE	0	0	3	2	2	5	1	2	3
		FEMALE	0	0	6	1	2	2	0	0	1
	COLORED	MALE	6	3	13	17	8	28	28	24	45
		FEMALE	0	5	18	0	4	34	5	19	36
	TOTAL		6	8	40	20	16	69	34	45	85
			PRIM.& SEC.		E.L.	PRIM & SEC.		E.L	PRIM & SEC		E L
PRIVATE PHYSICIANS	WHITE	MALE	5		7	6		6	11		30
		FEMALE	3		9	1		7	2		19
	COLORED	MALE	4		12	6		15	16		36
		FEMALE	3		15	5		33	7		44
	TOTAL		15		43	18		61	36		129
OTHER CLINICS HOSPITALS AND INSTITUTIONS	WHITE	MALE	0		0	2		0	3		2
		FEMALE	0		1	1		2	2		1
	COLORED	MALE	4		10	0		6	2		14
		FEMALE	0		12	0		8	4		7
	TOTAL		4		23	3		16	11		24
	TOTAL BY STAGES		33 (P&S)		106	57 (P&S)		146	126 (P&S)		238
	TOTAL EARLY SYPHILIS		139			203			364		
						(46% RISE)			(79% RISE)		

1958. The rise in total syphilis, including the late stages, was 13 per cent in 1958 over 1957 and 69 per cent in 1959 over 1958. This upsurge becomes more dramatic when we note the 90 per cent rise of newly discovered total syphilis in 1959 over the total in 1957; and the 200 per cent increase of early syphilis in 1959 over 1957.

The incidence of the infectious and early syphilitics in our clinic and across the country is highest in both sexes in the 20 to 24 year old group. In men, the second and third highest age groups are 25 to 29 and 15 to 19 respectively. In women they are 15 to 19 and 25 to 29 respectively. The clinical appearance of syphilis as we see it today does not differ from infectious syphilis of other years.

In the typical male genital chancre from which spirochaets can be obtained easily, there is a sharply outlined, firmly rimmed ulceration with a relatively easily bleeding base. For all the apparent induration and inflammation, sensitivity and pain are minimal. There will be the usual associated inguinal lymph node enlargements which, in spite of their firmness and tenseness, are relatively painless.

In the female, detection of primary syphilis is not quite so easy because of the occult location and painlessness of the customary chancre and because the regional lymph glands of the female genitalia are not as accessible to examination.

TABLE 2.

NEWARK, NEW JERSEY — SYPHILIS — ALL STAGES (FROM CLINIC ONLY)

	1957	1958	1959
PRIMARY	6	20	34
SECONDARY	8	16	45
EARLY LATENT	40	69	85
TOTALS OF EARLY SYPHILIS	54	105 (94% RISE)	164 (56% RISE)
LATE SYPHILIS	251	239	417
TOTAL NEW SYPHILIS OF ALL STAGES	305	344 (13% RISE)	581 (69% RISE)

In the pre-penicillin days it was not uncommon to find chancres in sites other than on the genitals. These were generally transmitted by kissing.

Secondary lesions are highly infectious and a dark field examination can demonstrate spirochaets in the untreated lesions. A positive serology is always present.

The cutaneous manifestations of syphilis show considerable pleomorphism. They may

simulate many other eruptions and form macules, papules, pustules, or combinations of these lesions. Vesicles do not occur and bullae occur only in congenital syphilis of the newborn. Major criteria for the diagnosis of secondary syphilis are:

(1) Positive serology and positive dark field.
(2) The lesions are discrete, often grouped and polymorphic, including many bizarrely shaped configurations.
(3) Mucosal lesions.
(4) Frequent generalized small, discrete, painless lymphadenopathy.
(5) Mild to moderate constitutional symptoms including fever, anorexia, headaches, arthralgia, and iritis.

The proper management of these patients must include a careful epidemiologic work-up, plus a medical evaluation. Interviewing to obtain as many contacts as possible is performed on the patient's first visit. It is the concentrated investigative activities by skilled and considerate personnel that offer our best chance to reverse the rising rate of infectious syphilis.

DIAGNOSIS

WE MUST establish the diagnosis as promptly as possible and report it to the proper authorities. A minimal diagnostic requirement, in addition to the clinical findings, should be a positive qualitative and subsequent quantitative serologic test, especially in the absence of a positive dark field. Where there is a suspicion of syphilis and where the blood test, in the absence of lesions, is negative, the test should be repeated no later than in one month and sooner if indicated. If it remains negative and if syphilis is still suspected, repeat the test monthly for four months.

The dark field examination, when positive, permits a diagnosis of syphilis even before the serologic test becomes perceptively positive. The diagnosis of primary syphilis, while it is still sero-negative, represents modern medical practice at its best. Therapy can be started immediately to stop progressive development of the disease and to prevent its spread to others.

†We used the Wyeth brand tradenamed Bicillin®.

The diagnosis of sero-positive primary syphilis or of secondary syphilis offers no problem. The diagnosis of latent syphilis depends on the laboratory data, with or without the corroborating history.

The only means of accurately diagnosing neuro-syphilis and of subsequently evaluating its treatment is by spinal fluid examination. However, such a procedure is no longer as important as it was in the pre-penicillin days. If a suspected neuro-syphilitic patient is reluctant to submit to a spinal fluid examination, we treat him for the suspected neuro-syphilis. Six months later, we try to persuade him to permit the spinal fluid test to evaluate the effectiveness of the treatment. Our spinal fluid examination includes a cell count (done immediately) a quantitative serology test, a total protein determination, and occasionally a colloidal gold test.

TREATMENT

MODERN treatment of all stages of early syphilis and of late latent syphilis has been simplified to where 2,400,000 units of benzathine† penicillin-G, given during a single visit will suffice. Four cubic centimeters are administered into each buttock intramuscularly. Penicillin aluminum monostearate (PAM), although no longer popular, may be substituted. (See Table 3).

Some authorities believe that this single dose of 2,400,000 units of benzathine† penicillin-G will be adequate for asymptomatic neuro-syphilis and for the other active stages of late

TABLE 3.

BICILLIN ANTI-SYPHILITIC THERAPY

STAGE	DOSAGE
ALL EARLY SYPHILIS LATE LATENT	2,400,000 UNITS IM AT A SINGLE VISIT
NEURO-SYPHILIS CAROIO-VASCULAR OTHER LATE SYPHILIS	2,400,000 UNITS IM AT EACH VISIT REPEAT AT 5-7 DAY INTERVALS TO TOTAL OF 7.2 TO 9.6 MILLION UNITS
CONGENITAL EARLY LATE	UP TO ONE-HALF OF ADULT DOSAGE FULL ADULT DOSAGE (CONSULT FOR COMPLICATIONS)
GONORRHEA (SYPHILIS ALWAYS A THREAT)	1,200,000 UNITS IM AT A SINGLE VISIT (IN THE ABSENCE OF INDICATIONS OF SYPHILIS)

syphilis (except active neuro-syphilis). I have not felt 'comfortable' in limiting therapy to this single treatment in these categories. At our clinic we give 7,200,000 units of benzathine† penicillin-G subdivided into 2,400,000 unit doses, generally at seven-day intervals. Where the neuro-syphilis is active, we have assuaged our conscience further by administering a fourth dose for a total of 9,600,000 units.

Pre-natal syphilis is treated according to the mother's stage of the disease. She should be re-treated if in doubt as to the adequacy of any previous therapy.

Early congenital syphilis is rarely seen any more in our clinic. The New Jersey Department of Health has recommended one-half the adult dosage, or 1,200,000 units of benzathine† penicillin-G.

Late congenital syphilis generally is treated with a full adult dosage, according to the clinical manifestations.

Interstitial keratitis does not respond well to anti-syphilitic therapy alone, requiring topical steroids and possibly other supportive treatment in collaboration with an ophthalmologist.

Many people are sensitive to penicillin; some of them can take penicillin therapy without difficulty provided an adequate antihistamine regime accompanies the penicillin. However, there are patients to whom penicillin cannot be given. Erythromycin or Carbocycin® (Magnamycin®) given in 500 milligram doses every 6 hours for 8 to 10 days (16 to 20 Grams) in early cases, and for 10 to 15 days (20 to 30 Grams) in late cases, is our presently recommended alternative regime.

Oxytetracycline (Terramycin®), chlortetracycline (Aureomycin®), or chloramphenicol (Chloromycetin®) may be given in doses of one Gram 4 times a day at 6-hour intervals for 8 to 10 days (30 to 40 Grams). These are satisfactory substitute medications.

One type of treatment reaction which no longer disturbs us greatly is the Herxheimer reaction. It is generally transient, occurring within twelve to sixteen hours from the start of therapy and is common in the treatment of early syphilis. It is often unnoticed by the otherwise healthy, young patient. Under penicillin therapy, if the patient with cardio-vascular syphilis is adequately compensated, his penicillin may be started in full doses without preliminary heavy metals and without fear of a Herxheimer complication of significance.

In patients with paresis, we may more frequently see Herxheimer reactions varying from mildly increased agitation to a short-lived convulsion due to the rapid destruction of numerous treponemes in the cerebral cortex. Penicillin therapy may be continued while the patient is controlled with sedation.

FOLLOW-UP

Subsequent to the completion of penicillin therapy, we concern ourselves with the follow-up care. In primary and secondary syphilis, sero-negativity usually occurs in twelve to eighteen months, but in 10 to 20 per cent of these patients, a low titer may persist slightly longer. Optimal follow-up care is a blood test and clinical examination monthly for six months and subsequently at increasing intervals. The spinal fluid should be examined at a minimum of six months and preferably about twelve months after therapy, unless there is reason to suspect a development of treatment-resistant syphilis.

Late syphilitics may remain sero-positive for many years and the mere persistence of a positive serologic test is not an indication for re-treatment. However, as in early syphilis, the progressive rise in titer, the retention of a markedly high titer, or the uncommon reappearance of lesions suggests the need for re-treatment. Clinical examinations, spinal fluid determinations and judgment must then be combined to determine if re-treatment is necessary.

In neuro-syphilis, treatment evaluation requires repeated spinal fluid examinations which, except for clinical evidence of further deterioration, can be adequately performed at

six-month intervals. Criteria of improvement include a cell count which is normal or approaching normal within six months after successful therapy. By the end of two years the quantitative tests, both protein and serologic, should show definite improvement. Central nervous system pathology is destructive and its effects are essentially irreversible so that the lack of improved function does not mean the failure of our anti-syphilitic therapy. Relapse of neuro-syphilis after two years is very unlikely.

ANTIGEN TESTING

Our evaluation of the results of treatment, as well as the establishment of a diagnosis of syphilis in a patient with otherwise doubtful criteria, has been improved recently by the development of a series of tests depending upon the use of treponemata as an antigen.

In 1949, Nelson and Mayer [18] demonstrated that syphilitic serum could immobilize virulent treponema pallida organisms. It was expected, due to the specificity of the antigen, that this test, the T.P.I., was the long sought-after "infallible" test for syphilis. However, it is expensive and difficult to do and results vary from laboratory to laboratory. It becomes positive later than do the presently used tests. In successfully treated syphilis it is at least equally slow in becoming negative. While the T.P.I., in skilled hands may still remain the standard for comparison with other tests, its routine use has not been feasible. Subsequently the TPCF (treponema pallidum complement fixation), TPIA (treponema pallidum immune adherence), and the RPCF (Reiter Protein Complement Fixation) tests have been developed.

The RPCF is relatively inexpensive and uses a protein extract of the Reiter treponeme which was obtained originally from the spinal fluid of a neuro-syphilitic patient. It is of doubtful pathogenicity and has been easily and inexpensively cultured, making it readily available as an antigen. Because the RPCF is easier to perform, with results which do not vary significantly from laboratory to laboratory, its popularity is increasing.

In the detection of early syphilis, the RPCF and VDRL tests 'behave' essentially the same. The TPI test will become positive more slowly but will gradually coincide with the other two tests.

In late syphilitics the RPCF eventually reverts to negativity in the same proportion as does the VDRL test. The TPI reverts more slowly.

In the non-syphilitic the RPCF test roughly parallels the TPI test, including in false biologic tests.

CONCLUSION

Syphilis is again an actively infectious disease increasing in incidence. The diagnostic armamentarium of laboratory tests has changed our concept of the results to be obtained. The management of the patient and the simplified therapy with its greater effectiveness have improved the expected end results. While the management of syphilis still depends largely on the laboratory findings, it is again a disease in which the physician must employ his keenest clinical acumen and most seasoned judgment.

299 Clinton Avenue

Bibliography will appear in author's reprints.

RICHARD A. HOPPING, M.D.

East Orange

Diseases of the Lower Bowel in Older People*

Though the details change, the principles of surgery remain the same. Here, as Dr. Hopping points out, is a group of patients requiring special tactical considerations—but these, too, are only parts of the fundamental and unchangeable set of principles for sound medicine and sound surgery.

THE incidence of disease involving the terminal bowel increases with age. This is coincident with an increased preoccupation with matters pertaining to the lower bowel which is so common in oldsters. "As interest in things sexual wanes, there waxes an interest in things fecal." Preoccupation—sometimes overly exaggerated—with the daily evacuation is common with advancing years and is often associated with erroneous, fixed ideas. Progress has been made recently on these difficulties but much more has to be done in the future. Bizarre cases are not unusual. The ingenuity, imagination, and patience of the attending physician are frequently taxed to find satisfactory solutions. Compromises are necessary when the ideal treatment is beyond the physiologic capabilities of the elderly patient.

THE FIRST CONTACT

FROM the moment of first contact, everything must be done to attain and maintain a warm, cordial and trusting relationship between the physician and his patient. Successful management begins with the introduction to the patient. Elderly people respond to genuinely extended warmth and understanding. A seemingly immoderate amount of time must sometimes be expended on small talk and generalities before the spark of friendship and mutual agreeableness is struck. Crabbiness and irritability must be soothed. Suspicion must be disarmed. Fears must be allayed. When the history is taken, the help of friends and relatives should be welcomed and enlisted. The interchange of expression, the clarification of obscure complaints when a third party is present during an interview are helpful in the evaluation. Much time must be spent probing for symptoms and establishing reciprocal understanding of idiom and expression. The result of patient listening and inquiry is usually rewarding. It takes time to establish just what a complaint of "locked bowels" actually means to the patient himself. "Locked bowels" can mean the difficult passage of scybala due to a low residue diet necessitated by poorly fitting dentures. It can mean an obstructing carcinoma, an irritable bowel syndrome, or an idiopathic chronic ulcerative colitis.[2] It is commonly found to be the result of laxative abuse. Sometimes the purpose of this complaint is

*Presented at the Annual Meeting of The Medical Society of New Jersey, General Practice Section, May 18, 1960, Atlantic City.

simply to attract attention not otherwise offered to a lonely and forgotten oldster. The complaint may be entirely "imaginary" or due to fixed ideas. Intelligent probing can save time and money for the patient. Laxative habituation, enema abuses, and fixed ideas in patients will often be found to be more tiresome, trying problems for the physician to overcome than many major difficulties.

History taking for the proctologist can be narrowed down to nine principal lines of inquiry: the principal or chief complaint, the rectal complaint, bleeding, protrusion, itching, pain, abscess formation, bowel habit, previous treatment and medications. The history-taker must not fall into the trap of over-simplification. Each inquiry must be pursued diligently. For instance, if the patient has noted bleeding, the inquisitor must establish amount, frequency, color, consistency, the factors which provoke or initiate its appearance, whether it is in, on, or after, or before stooling, and, if it is noted on clothing, tissue, or only after scratching. All nine lines of inquiry must be pursued in just as painstakingly extensive a manner. During the history taking the physician will simultaneously begin evaluation of the patient. Preliminary estimation of the capabilities and alertness of the patient is made. The avenues of treatment available for the particular patient can be weighed for practicability and safety.

After a general and complete physical examination, particular attention is directed to the terminal bowel. Examination and palpation of the anorectal area will reveal disease conditions in more than 50 per cent of all patients examined. The examiner must not accept the obvious, however. Proctosigmoidoscopy must be done on all patients with large bowel complaints, particularly when bleeding has been noted. This is a simple and safe procedure in trained hands. It is a useless procedure unless the examiner has an excellent knowledge of gross pathology. A thorough sigmoidoscopy will satisfy the most fastidious diagnostician in better than nine out of ten cases, especially when combined with a test for occult blood[6] at the upper limit scoped. The remaining diagnostic problems require the services of the diagnostic roentgenologist[1] using the barium enema and barium meal, both, necessarily under fluoroscopic control.

EVALUATION OF THE CASE

After a satisfactory diagnosis has been made, the patient must be evaluated. Here is where the oft-lauded and frequently abused term, "the art of medicine," attains a lofty niche. Evaluation is difficult and often the most important guides are to be found in the physician's own background and experience. Treatment must be tailored to the needs and adjusted to the capacities of each patient and (this is most important) to the capabilities and environment of each particular physician.

The ideal elderly patient is alert and mentally clear. He is cooperative; wants to help himself and his doctor and he has no other demonstrable diseases. Would that such were the average elderly patient! A doddering, lethargic or irrational patient can seldom be transformed by improving liver, kidney, or heart function.[7] He usually remains a poor surgical risk. A mentally clear patient is the most important factor to consider when evaluating treatment. Obesity and hypertension are, in my experience, next in importance as factors to be weighed when the patient's potentials and capacities are evaluated.[12] Diseases of metabolism are next in importance. These diseases can often be considered as minor influencing factors when controlled by adequate measures. The ravages of cardiac, hepatic and kidney disease can frequently be stabilized and sometimes negated as risk factors. The physician must weight the difficulties and hazards thoroughly before he can intelligently advise the patient and recommend a regime. The surgical risks for cure under certain conditions may be greater than the patient can tolerate. The mechanical alleviation of symptoms may be subject to complications more hazardous than the disease condition itself. On the other hand, disease processes are, unfortunately, often progressive and prone to complications.

Is palliation going to be tolerable? Is the medical care proposed adequate? Is it proper to propose a hazardous or complication-ridden course of therapy which may very well shorten a life whose flame is already flickering disasterously near the extinguishing point? That so many of the problems of the ailing oldster can be solved satisfactorily is a tribute to medical progress and teamwork.

TUMORS, particularly malignancies of the terminal bowel, account for less than 10 per cent of our patients and must be considered surgical diseases except for the rare radiosensitive ones. Most tumors, fortunately, are benign. After biopsy, they may be destroyed easily, using the sigmoidoscope and whatever destructive modus is easiest. In the hands of a trained and experienced proctologist, risks are negligible and anesthesia is seldom necessary.[5] Malignant tumors still require great surgical and anesthetic skill.[12] Here the risk to the patient is considerable even under ideal conditions.[8] Incurable malignancy of the rectum has no satisfactory solution. The word, "palliation," has an empty, hopeless ring. The procedure of proximal colostomy without removal of the primary lesion, when possible, is not to be regarded tolerantly any longer. Complete removal of the primary lesion will prolong life and give relief of symptoms for a year or more.[11]

Diverticulitis of the terminal bowel is common.[9] Surgery is seldom necessary and may be required only for complications or for intractable cases with recurrent and localized disease. An acute episode of idiopathic ulcerative colitis is occasionally seen in elderly people.[2] It may be the first episode or an exacerbation in the course of a long smouldering disease. More than half of these patients survive with medical supportive measures and remain healthy. About 10 per cent need surgery. The mortality rate, overall, is about 30 per cent. Diarrheal states are not uncommon in the elderly and some can be classified as due to dietary deficiencies. Vitamin B and C levels are usually low in elderly people. Some cases in this category will respond to a gluten-free dietary regime. Sorboquel® (white) may help.

Hemorrhoids commonly cause elderly people much difficulty. They can generally be palliated with success. However, an occasional patient has enough blood loss or discomfort, or both, to necessitate a proctologic surgical consultation. Anorectal infection with cryptitis, abscess and fistula are uncommon and usually require mechanical cure. Fissure *in ano* is unusual in the aged. An open ulcer at the anal verge is to be regarded with suspicion. It should be treated as a malignancy until proved otherwise by adequate tissue studies. "Contracted anal outlet" is a common diagnosis and is usually associated with the prolonged use of laxatives or mineral oil or with loose and watery stools. The cure is surgical. Simple dilation will not work. Divulsion under anesthesia is thoroughly condemned. Dilators are more conducive to the satisfaction of anoeroticism than an effective therapeutic agent. Enlarged anal papillae commonly occur with a contracted anus and are frequently mistaken for premalignant polyps. Cure of these squamous-covered benign tumerfactions is surgical. True procidentia responds well to minimal surgical treatment with implantation of a constricting wire ring in the tissues of the anal orifice.

PREPARATION FOR SURGERY

PREPARING the elderly patient for surgery involves many concerns. Ideally, the patient should be mentally and physiologically stabilized and conditioned. An alert, cooperative patient is very desirable. He can be prepared for his coming surgical experience and acclimated to hospital living. He should know and be able to anticipate hospital routines. He can be "helped to help himself." It is possible to condition the patient by suggestion so that he can approach surgery with a receptive and perceptive mental attitude. Physiologically, the blood volume should be at optimum before surgery. Diabetes should be well under control. Cardiac and renal discrepancies should be compensated. Hypertension states and obesity can in-

fluence surgical morbidity and mortality profoundly. If these can be controlled without losing too much valuable time, it is well to do so before surgery is attempted. The bowel lumen should be clean and empty. The bacterial count can be reduced, if necessary, by any number of chemotherapeutic regimes. An empty bowel is usually best attained by a low residue diet combined with repeated cleansing enemata for a day or two before surgery. Vitamins B, C, and K should be given routinely pre-operatively and especially if sterile bowel preparation is considered. Pre-operative sedation is usually prescribed in a reduced dosage. A leisurely and thorough workup should be the rule. The acute surgical problem is an exception. In this case the preparation, though necessarily short, should be as complete as possible with emphasis on attainment of an adequate blood volume, control of cardiac deficiencies, reduction of blood urea level, and pulmonary clearance. Surgery in an emergency is best restricted to measures calculated to make the patient comfortable during the time required for a more adequate estimation and workup, after which, the definitive procedure may be done. Actual surgical technic requires no comment since the basic principles involved are invariably the same.

ANESTHESIA

GENERALLY speaking, the risk involved in doing anorectal surgery is no greater than the risk of the anesthetic used. A good and quick recovery from anesthesia is of prime importance because with good selection of surgical patients and good preparation, immediate and late convalescence is as smooth, and wound healing as fast as in more youthful individuals. Anesthesia in elderly patients is a subject in itself and will be explored in no great detail here.

Close cooperation between internist, surgeon, and anesthesiologist should be maintained. The functional reserve of an elderly patient is not great.[13] In order of desirability and of safety, the anesthetic modes of choice are: local infiltration, regional block, spinal, and, finally, general anesthesia. If general anesthesia is used, the position of the patient during surgery is usually limited to the lithotomy or Sims' position with or without intubation and mandatory minimal manipulation of the patient. With edentulous patients a mask is unsatisfactory and an airway is necessary for good control. Elastic leg bandages may bolster the reserve of an occasional patient.

POSTOPERATIVE CARE

POSTOPERATIVELY, a good patient is an alert patient with excellent cough reflex. Active, early ambulation and self-help are encouraged. Sedation must be minimized at the expense of some discomfort. Attractively presented, carefully selected food is served as soon as possible. Normal bowel habit should be initiated as soon as possible after anorectal surgery. Consequently, the menu, when possible, is bulky in character. Supplementary bulk is sometimes added to the diet. Laxatives, and especially mineral oil, are avoided. Vitamin B complex and C are given in relatively high dosage. Attention is directed toward the healing wound. An immaculate, dry wound heals with dispatch and these wounds are therefore maintained in that state. The "mood medicines," if given, are selected with care. Occasionally the gonadal hormones will provide a boost in postoperative morale by increasing alertness and appetite. However, the old adage about "whipping a tired old horse" is not without foundation in fact. So caution is in order.

Postoperative complications in elderly patients are much the same as in other age groups. Hemorrhage and impaction are the most common. Bleeding is dangerous only when not recognized. It is controlled best by an internal pack if no single external vessel can be quickly and easily seen and ligated.[14] Impaction can only be avoided by daily scrutiny and individualized care. There are no substitutes for these. Daily and more frequent flushing of the low and midrectum will avoid

this unpleasant situation and no other measures such as laxation, use of bulks, or mineral oil will substitute satisfactorily for this measure. Difficulty with initiation of voluntary voiding can be avoided by good pre-operative preparation and suggestion. If and when it is encountered, an indwelling catheter left in place for forty-eight hours or so usually will solve the problem. Cortisone, locally, combined with frequent and immaculate attention to local hygiene seems to minimize granulation and the otherwise inevitable and subsequent, excessive, and undesirable scarring.[15]

The end result of anorectal surgery in the selected elderly patient is satisfactory and satisfying to both the patient and the physician. The slightly increased risk is far outweighed by the benefits of good results.

144 South Harrison Street

BIBLIOGRAPHY

1. Andren, L. *et al.*: Gastroenterology, 36:631 (May 1959).
2. Bergan, J. A.: *Chronic Ulcerative Colitis.* Springfield, Illinois 1951. Thomas.
3. Case, T.: Journal of the American Geriatric Society, 6:526 (January 1958).
4. Flood, M. *et al.*: Journal of Chronic Diseases, 4:267 (September 1956).
5. King, O. C.: Geriatrics, 11:488 (November 1956).
6. Mills, G. *et al.*: Geriatrics, 10:366 (August 1955).
7. Moore, F. D.: *Metabolic Care of the Surgical Patient.* Philadelphia 1959. Saunders.
8. Patterson, H. A.: Diseases of the Colon and Rectum, 2:109 (February, 1959).
9. Reider, R. A.: Geriatrics, 13:790 (December 1958).
10. Schoenberg, H. W. *et al.*: Geriatrics, 13:718 (November 1958).
11. Stearns, M.: Journal of the American Geriatric Society, 3:731 (September 1955).
12. Zlifer, H. D. *et al.*: Journal of the American Geriatric Society, 5:284 (March 1957).
13. Jemerin, E. E.: American Journal of Geriatrics, 8:185 (March 1960).
14. Walker, G. L. and Nibro, M. D.: Surgical Clinics of North America, 39:1655 (July 1959).
15. Schneider, H. C.: Journal of the International College of Surgeons, 33:208 (February 1960).

Mobile Operating Rooms

Mobile operating rooms that could go to the aid of heart attack victims are suggested by Claude S. Beck and David S. Leighninger, writing in the Sept. 10 (1960) *Journal of the American Medical Association.* They urge that mobile units be sent to victims whose hearts are revived by the open chest, manual massage technic.

Purpose of the mobile operating units would be to restore the heart to a normal rhythm and close the chest at the scene of the emergency. Success is more likely if the operating room with trained personnel is moved to the victim instead of the victim being moved to the hospital. Artificial respiration, essential to survival, may be interrupted while he is being transported to the hospital, they pointed out.

The surgeons made the recommendation after reviewing the incidence of death in "hearts too good to die." A survey of 500 heart attack victims listed by the Coroner's office in Cleveland, showed that in 63 per cent of the cases there was no evidence of sufficient heart damage to cause death. Leighninger and Beck explained that a good heart could fail when its supply of oxygen is cut off or when its oxygen becomes unequally distributed causing fibrillation. Anoxia can be caused by suffocation, choking, or drowning. Fibrillation can be caused by lightning striking the body.

When a structurally sound heart stops beating, it may need only a "second chance" to cheat death. The cardiac massage technic is becoming increasingly successful in surmounting the temporary difficulty of the healthy heart.

ALEXANDER KARFOPOULOS, M.D.

Bayonne

A Safe Effective Anesthesia for Cystoscopies*

The pain and discomfort of cystoscopy has often been a bar to careful urologic diagnosis. The development of a swift, safe and effective cystoscopic anesthesia is good news to all practitioners.

MANY candidates for cystoscopy are elderly males who, because of age, debility, chronic prolonged uremia, dehydration and acidosis secondary to obstruction, are not ideal subjects for general anesthesia. The morbidity and mortality of general anesthesia in older patients is a significant consideration. Spinal anesthesia has proved effective in providing safe, effective pain relief; however, all too frequently headache results, producing several days of sickening discomfort for the patient.

These factors directed our search towards agents that would provide adequate anesthesia, allowing a proper cystoscopic examination and give the patient complete relief from pain and anxiety. We decided to evaluate the combined use of Doriden® as a pre-anesthetic agent and 2 per cent Pyribenzamine anesthetic jelly or solution. Previous reports [1,2,3] concerning Doriden® as a pre-anesthetic hypnotic in a variety of conditions indicated a high degree of effectiveness; and 2 per cent Pyribenzamine has also proved to be an effective topical anesthetic of low toxicity.[4] The combined use of these agents seemed to offer a rational answer to our anesthesia requirements.

Doriden® is a short acting, sedative-hypnotic which does not have many of the toxic effects commonly associated with barbiturates or narcotics.[5,6] It has no toxic effects on the hematopoietic system, the liver, or the kidneys.[7] Patients awakening from Doriden®-induced hypnosis generally do not experience the mental fogging noted with barbituric acid hypnotics or narcotics.[8] Doriden® has been used with satisfactory results as a pre-anesthetic hypnotic in children,[6] obstetric patients,[9,10] for cystoscopic examinations,[2] and in a variety of general surgical procedures.[1,5,6] The satisfactory use of Doriden® has also been reported in aged patients whose poor response to barbiturates and narcotics is notorious.[7]

Pyribenzamine has been effectively used as an

*This work is from the Bayonne Hospital where Dr. Karfopoulos is resident in urology.

1. Matlin, E.: Doriden®, A Clinical Study. M. Times, 84:68 (1956).

2. Burros, H. M. and Borromeo, V. H. J.: Ethyl-alpha-phenyl-glutarmide as a Sedative for Pre-cystoscopic Sedation. J. Urol., 76:456 (1956).

3. Hodge, J., Haskell, B. F. and Rovner, H.: A New Non-barbiturate-Hypnotic Agent in Pre-operative Sedation. Am. J. Surg., 94:108 (1957).

4. Sheddan, F. G., Jr. and Belanger, P. M.: Tripelennamine in Urologic Procedures, New England J. Med., 252:141 (1955).

5. Hodge, J., Sokoloff, M. and Franco, F.: Experiences with a Non-barbiturate-Hypnotic Agent in Respiratory Diseases. Am. Pract. & Digest. Treat., 10:473 (1959).

6. Branch, D. R. and Pastorello, R. R.: Use of Glutethimide for Pre-operative Medication. New England J. Med., 257:125 (1957).

7. Lane, Robert A.: A New Sedative-Hypnotic Agent in Elderly Patients. New York J. Med., 55:2343 (1955).

8. James, J. W. B.: Psychiatric Disorders in Pregnancy, In: Aids to Obstetrics, 12th ed. by L. Williams. Bailliere, Tindall & Cox, London (1949).

9. Bennett, J. S.: Glutethimide in Obstetrics. Canad. M. A. J., 30:28 (1959).

10. Graves, Lester R., Jr.: Glutethimide in the Labor Patient. Am. J. Obst. & Gynec., 7:1324 (1958).

antihistaminic for many years, although its potency as a topical anesthetic is less widely known. Rosenthal and Minard[11] first demonstrated the capacity of antihistamines to induce local anesthesia of a significant degree. Subsequent studies with pyribenzamine indicated its usefulness as a topical anesthetic in gastroscopy, oral surgery, otolaryngologic procedures, and proctology.

The report that stimulated our usage of 2 per cent pyribenzamine jelly and solution as a topical anesthetic for cystoscopy was that of Fitzpatrick, Orr, and Stubbart.[12] They said that of 100 patients who had been cystoscoped on separate occasions with pyribenzamine and Metycaine®, 82 per cent preferred the results with pyribenzamine, 14 per cent felt it was equal to Metycaine® in effectiveness, while only 4 per cent felt better results were obtained with Metycaine.®

Pyribenzamine has been noted to have an anesthetic potency four times greater than an equivalent amount of procaine. Although its anesthetic effect does not persist as long as procaine, its use in urologic procedures provides anesthesia lasting approximately one hour, thus permitting adequate examination.

As the urethral mucous membrane has been shown to be a very effective absorbing surface, not infrequently the use of "caine" anesthetics in sensitive patients has produced serious toxic and atopic manifestations. An occasional fatality due to severe anaphylaxis or cardiac arrest has been reported with the intraurethral instillation of "caine" derivatives. Absorption of pyribenzamine from the urethral mucosa has occasionally produced drowsiness and a sensation of lightheadedness; however, there have been no reports of serious toxic effects from its topical use as an anesthetic.

We used a 2 per cent concentration of pyribenzamine in a stable, sterile, aqueous jelly or in a clear, nonviscous, sterile, stable solution which can safely be introduced into the bladder. The 2 per cent pyribenzamine jelly is provided in 30 cubic centimeter tubes with a convenient tip that allows easy introduction of the medication into the male or female urethra. The solution can be resterilized, if necessary, by boiling or autoclaving with no loss of potency.

Each patient studied received 500 milligrams of Doriden® on the evening prior to cystoscopy or manipulation. On the morning of the procedure, one Gram of Doriden® was administered at either one, one and one-half, or two hours prior to the onset of the procedure. The effect of the pre-anesthetic agent was evaluated in the operating room.

Pyribenzamine anesthetic solution or jelly† was then introduced in the urethra and applied about the urethral orifice. The technic consisted of instilling 5 cubic centimeters of the solution, or 20 cubic centimeters of the jelly, into the urethra. In the males, a penile clamp was applied after the medication was instilled, and gentle massage of the penis promoted dispersion of the medication throughout the entire urethra. Anesthetic effect was enhanced in female patients by introducing a cotton tip soaked in the solution into the urethral orifice. When the anesthetic jelly was used in the females, this was not necessary. Five minutes were allowed for the anesthetic to take effect. The level of anesthesia thus obtained was evaluated with the introduction of the endoscope and/or urethral dilators when used.

RESULTS

THIRTY-THREE patients were evaluated using this routine. The patient group included 5 females. The indication for the cystoscopy and manipulation included hematuria, urethral obstruction, nephrolithiasis and ureterolithiasis, ureteral stricture, bladder papillomata, and retrograde pyelograms. Using this program of anesthesia, 33 cystoscopies were done, 9 retrograde pyelograms, 5 catheterizations of the renal pelvis, 3 urethral dilatations, and 1 fulguration of a papilloma. For the patient with a papilloma, pyribenzamine jelly was used to anesthetize the urethra. When the tumor was

†The Doriden® and 2 per cent Pyribenzamine anesthetic jelly and solution used in this study were provided through Dr. Robert D. Graupner of CIBA Pharmaceutical Products, Inc., Summit, N. J.

11. Rosenthal, S. R. and Minard, D.: Histamine as Mediator for Cutaneous Pain. J. Exper. Med., 70:415 (Oct.) 1939.

12. Fitzpatrick, R. J., Orr, L. M. and Stubbart, F. J.: Antihistamines for Urethral Manipulation. Journal of the American Medical Ass'n., 150:1092 (1952).

discovered, 10 cubic centimeters of pyribenzamine anesthetic solution diluted in half with sterile water was introduced into the bladder to produce anesthesia.

The pre-anesthetic state of all the patients was satisfactory. They were relaxed, tranquil, and seemed indifferent to the procedures going on about them. Although drowsy or sleeping, they could be roused easily. Vital signs remained normal. No instances of respiratory depression were noted. There was no nausea or vomiting. The optimum time to administer Doriden® was one hour prior to the procedure. Since completing this study, we have used 1.5 Grams of Doriden® in very apprehensive patients one hour prior to surgery with excellent results.

After topical anesthesia was induced (and in each instance, 5 minutes proved an adequate time) instrumentation proceeded with ease in all cases except one male patient who complained of pain and burning after the introduction of the jelly into the urethra. In this case, a spinal anesthetic was used.

Duration of anesthesia was adequate in all cases and varied between 30 to 60 minutes after a single treatment with pyribenzamine. Most patients had good anesthesia for 45 minutes.

Because both the solution and jelly are water soluble, there was no obscuring of the lens of the endoscope. Interference with visualization was not a problem.

In addition to the case already noted, only one other patient complained of any urethral stinging after the introduction of the anesthetic agent. This decreased progressively in intensity and lasted less than 15 minutes. Only 2 patients in the group (5 per cent) noted this effect, and in only one was it of sufficient intensity to alter treatment.

Postoperatively, the patients recovered from the effects of hypnotic and the topical anesthetic without untoward events. There were no instances of nausea, vomiting, headache, or any abnormal alteration of vital signs.

SUMMARY

THE combined use of Doriden® as a hypnotic pre-anesthetic agent and 2 per cent pyribenzamine as a topical anesthetic in jelly† or as an aqueous solution provides a safe and fully effective anesthesia for cystoscopic examinations or urethral dilatations in the male or female.

Side effects associated with this anesthesia routine were minimal, particularly when compared to those noted with barbiturates, topical "caine" derivatives, narcotics, and spinal or general anesthesia.

The Bayonne Hospital

Meprobamate Overdosage

Writing in the August 1960 *Archives of Internal Medicine*, M. J. Ferguson and his colleagues remind us that meprobamate can be used as a suicide vehicle by the depressed patient. Eight patients with meprobamate overdosage were seen in a 12-month period at the St. Vincent's Hospital of the City of New York. A consistent clinical picture was observed. The outstanding features were severe hypotension without loss of response to painful stimuli or loss of deep tendon reflexes. Respiratory function was not significantly disturbed. Hypotension is stressed as the main therapeutic challenge. The importance of constant observation of vital signs during the comatose interval is indicated since hypotension may develop at any time during this period. All the patients were successfully managed with vasopressors. Analeptics and antibiotics were not used.

Bernard R. Goldberg, M.D.

Newark

Pseudo-Retardation*

Mental defectives are usually dismissed as untreatable, simple retardates. Yet in a series of 1107 such children, Dr. Goldberg found 103 who were essentially psychotic rather than defective. Family doctors and pediatricians should be on the lookout for psychotic symptoms (here spelled out in useful detail) in such children.

The term "pseudo-retardation" or "pseudo-feeblemindedness" indicates a satisfactory original endowment or innate capabilities combined with a handicap—motor, sensory, or emotional—that prevents the fruition of these abilities.

An attempt was made by the World Health Organization[1] to distinguish between *mental defect*, where there is diminution of mental capacities as a result of pathologic (physical) causes; and *mental retardation*, where educational and social performance is markedly lower than would be expected from what is known of the intellectual abilities. This proposed differentiation has not met with general acceptance. "Retardation" as used here would make the term "pseudo-retardation" superfluous.

The terms, "mental deficiency," "feeblemindedness," "mental inadequacy," and "subnormality," have been used interchangeably with mental retardation. The latter is most commonly used. It indicates broad phenomena in which there is an unusually slow or arrested rate of mental development.

Approximately one-tenth of one per cent of the children born yearly in this country are severely retarded.[2] Within this population, there is a segment of from 15 to 50 per cent of individuals who should be, strictly speaking, designated psychotic.[3]

Many articles[2,4,5,6,7] have been written in the past two decades on the relationship between psychosis and mental subnormality. Unfortunately their almost universal plea for sharper clinical study and research has been, for the most part, ignored. As a rule, the label, "functioning at a severely retarded level," rings down the curtain on further study and interest, even when this is accompanied by the qualifying phrase, "not testable." The psychologist knows that he is evaluating either the "functional" level of performance or the social scale supplied by the mother. This consists simply of her answers to questions about the child's abilities and performance. Other workers, including physicians, too often accept these as a diagnosis rather than a description of prominent symptoms. What is lacking in this approach is a recognition and evaluation of the frequent personality disturbances that accompany intellectual defect. In the severely retarded, these aberrations often round out a constellation of symptoms that spell "psychosis."

The term "psychosis" as applied to adults has had many vicissitudes in meaning since it was first used in the late 19th century as a substitute for "insanity." Psychiatric illness

*Read at the Annual Meeting of The Medical Society of New Jersey, Atlantic City, May 18, 1960. This work is from the Guidance Clinic for Retarded Children in East Orange.

was considered to be essentially a result of disease of the brain. The "psychotic" was separated from the "psychoneurotic" as being a hospital case, a more malignant condition, a "major" or "total" reaction, "inacessible," "irresponsible," and "unintelligible." Although volumes have been written about it, the term "psychosis" does not have a generally accepted definition.

When applied to children, it is even more difficult to reach agreement in terminology. Such helpful diagnostic aids as delusions and hallucinations are not present as in adults. For these reasons some workers avoid the label, "psychosis." However, it is generally agreed[8] that there are several types of mental disorders that cannot be included in the behavior disorders of psychoneurotic intensity and in which there is disruption of all forms of adaptation resulting in extensive disorganization of the personality.

We define psychosis in childhood as a condition or group of conditions developing in the first few years of life (before puberty) in which there is failure of and/or regression in ego development resulting in extensive disorganization (of the organism) at all levels of functioning: vegetative, motor, perceptive, emotional, intellectual, and social.

It includes such conditions as: infantile autism,[9,10] symbiotic and autistic schizophrenia,[11] pseudodefective schizophrenia,[12] severe emotional deprivation,[13,14] and psychoses associated with various brain syndromes. Although given different names, all of these can be considered schizophrenic reaction types.

Masland, Sarason, and Gladwin,[2] in their recent book, "Mental Subnormality," summarize the relationship between psychosis and mental deficiency as follows:

"1. Psychosis is found at all levels of subnormal functioning. Even in the case of idiots marked and dramatic psychotic-like changes in behavior have been noted—in some cases, apparently, the behavior is episodic while in others it is followed by deterioration.

"2. Psychosis occurs in cases with no discernible organic pathology as well as in those with marked pathology.

"3. Practically every major psychotic symptom which has been described in the nondefective patient has also been noted in many of the defective cases. There appears to be little justification for the generalization that when psychosis occurs in a mentally defective individual it is necessarily less 'complex' than when found in the nondefective individual. There is also little support for the equally sweeping generalization that psychosis or psychotic-like behavior in the defective individual tends to be of short duration.

"4. As a result of work in the last 20 years on childhood schizophrenia, there is little doubt that many children who were committed to an institution for the mentally defective were in fact misdiagnosed and misplaced. Kanner's now classic descriptions of the autistic child provided further evidence that our institutions contained cases in which personality or affective rather than intellectual maldevelopment was the primary factor. While one would like to believe that our institutions are admitting far fewer of these cases, there is no evidence that this is the case.

"5. The schizophrenic type of reaction is the most frequently found psychosis among the mentally defective.

"6. The incidence of mental illness among the mentally deficient appears to be much higher than in the general population."

Our experience at the Essex Unit of the New Jersey Association for Retarded Children parallels these conclusions. My experience with the psychiatric aspects of retardation covers a span of 12 years as consultant psychiatrist and includes the last 3 years as Medical Director to the Guidance Clinic for the Retarded.

In the 11-year period from 1949 through 1960, this clinic examined 1,107 children of whom 103, or 9.3 per cent, were labelled psychotic. A closer look at the records show that in the first four years (1949 to 53) the proportion of psychotic children was 4 per cent, in the next two years (1954 to 56) it was 7 per cent, during the following three years (1956-59) the proportion was 14 per cent.

The meaning of this increase may lie in one or more of the following factors:

1. Increased and improved diagnostic study;
2. Increasingly loaded referral process;
3. Increased incidence of psychosis in the general population.

Since there is no evidence to support the last, we attribute the increasing ratio to the other factors. The local knowledge that our

clinic has psychiatric diagnostic facilities is probably of some importance. The first factor, to which I attribute the rising ratio, follows from an increased proportion of children referred for psychiatric evaluation by social workers, psychologists, and pediatricians who have developed a keener awareness that aberrant behavior could not be assumed to be a *result* of mental defect, and thus required psychiatric examination.

THERE are many indications that the latter figure (14 per cent) is a minimal one. One of these is a pilot study in June, 1957, when instead of the usual method of screening applicants for psychiatric evaluation (*i.e.*, when social worker, pediatrician, neurologist, or psychologist saw what he thought were signs of major psychopathology), ten consecutive applicants were seen for psychiatric study. The rather remarkable result was that six of these (60 per cent) were found to be psychotic (of the remainder, two had organic disease, and two mongolism). The nonpsychotic also showed signs of emotional problems though not psychotic in calibre.

It has been said that, since we find psychosis associated with mongolism, phenylpyruvic oligophrenia, and other brain syndromes, the psychosis should be considered merely a psychiatric casualty of the brain disease, assuming the organic brain damage to explain *sui generis* the over-all behavior disturbance. Some go further and explain the resultant deviation in behavior to be the combined result of deficient function coupled with parental failure in understanding and handling. A third possibility is that the brain damage does not in itself encompass the type of behavior observed here, that it plays only an auxiliary role,[15] and the behavior is more specifically related to a breakdown of ego development.[16] For this reason, we find a similarity in the psychotic symptoms whether or not associated with brain disease. This is not meant to imply that no differences exist between the syndromes mentioned—it is only intended to highlight the similarities.

CLINICAL FEATURES

A. *History*: With an increasing familiarity on the part of the clinic staff, a careful history often supplies the essential symptoms preparatory to psychiatric diagnosis. As outlined by Shugart,[17] the material having primary diagnostic significance falls into five major areas of ego function:

1. *Orientation to People*: They are unable to form object relationships with people including parents and siblings, except the symbiotic child (where it is destructive).
2. *Orientation to Reality*: The child fails to respond to the world about; is undemanding, apathetic, indifferent or "too good."
3. *Orientation to Play*: He is markedly deficient in playfulness, shows no mutual play, prefers spinning wheels of cars, and repetitive play.
4. *Motility and Sensory Modes*: Use of the body in rhythmic or bizarre ways.
5. *Speech* is delayed or develops slowly and regresses.

A positive history usually contains most, if not all, of these disturbed functions and is the first phase in making a positive diagnosis.

B. *Sex Ratio*: The over-all clinic sample indicates a slight preponderance of male children (59 per cent male, or a 3 to 2 ratio). But there is a significantly weighted distribution in the psychotic group (70 per cent or a 2½ to 1 ratio). This approximates the usual ratio cited in most studies of childhood psychoses.

C. *Socio-economic Factors*: The income levels for families of psychotic and mentally retarded children both follow a similar distribution, approximately 92 per cent occurring with incomes of under $160 per week.

The majority of heads of families in both groups falls within the professional, executive, and "white collar" groups with only 20 per cent in "blue shirt" jobs. Less than 10 per cent are unemployed or dependent financially. Thus, the socio-economic rating of the two groups (a function of income and occupation) is comparable and can be labelled "good."

D. *Parent-Home Rating*: A significant difference exists between the two groups. Families containing psychotic children rate as "poor" in 54 per cent of the cases. None rates as superior. The ratings of families of retarded

children have 75 per cent fall into the median "good" and "fair" classes.

These ratings parallel a study reported by Goldfarb [18] in which it was found that the families of schizophrenic children (nonorganic) were aberrant in adequacy. Our rating is based on professional (social work) judgment of family organization, interrelationships, and attitudes towards children. It is not a controlled study and can be considered only a tentative lead. In addition, we did not separate the organic and nonorganic groups. It does, however, fall in line with the general hypothesis that psychoses in children are associated with disturbed families and, as indicated by Goldfarb's study,[18] it is not that the psychotic child produces the inadequate family but rather that more intensive and extensive study of this relationship is sorely needed to help separate out the relative importance of heredity, somatic deficit, and the primary difficulty in differentiation of child and mother.

E. *Age of Onset*: In 84 per cent of the cases, the first signs were noted by three years of age. When the figure is corrected by removing those in which the reporting is patently unreliable, this figure becomes practically 100 per cent. Because of the nature of the disease and the counter transference phenomena (always present in the mother) there is a considerable error on the side of putting off recognition of abnormality. Thus, in one of our patients, the mother did not observe anything unusual in her child until three years of age. But her sister, present during the interview, volunteered that they (the family) knew before nine months of age that this child was "slow and abnormal." The disease is usually well underway before speech is developed, giving rise to the most prominent symptom in all of our cases, namely, abnormal speech.

CHARACTERISTICS

1. Recognizable *speech* is either totally absent or severely distorted. It may be infantile with only repetition of gutterals or have one of many disturbances from total mutism to flat, bizarre utterances as described [19] by Goldfarb *et al.* in schizophrenic children. In one example, unintelligible speech was associated with extreme negativism. This child never spoke or answered when asked to but only did so when it was not solicited or expected at home. Because of the failure to develop speech (or its acute and tragic loss after some initial speech development) the chief means of communication between the inner and outer worlds of the child are not operative. Many symptoms result from this breakdown or from the failure of ego maturation.

2. *Distortion of Perception*: There is a marked *increase* in the use of "contact receptors" such as touching things, smelling, and mouthing. This kind of object relationship regularly accounts for 90 per cent of the child's contact with the world around him. It is, moreover, coupled with a *decrease* in the uses of distance receptors—sight and hearing—so that many children are thought to be deaf and/or blind or aphasic. Closer study reveals that *"they can hear but don't listen; they can see but don't look!"* Included also is the inability to tolerate sensations arising from gravity and proprioceptive stimuli.

3. Another consequence of the failure of normal ego development is *disturbance in motility*. This is always present in some form. Hyperactivity is the usual common denominator, but other indications of vaso-vegetative dysfunction are just as common, *e.g.*, persistence of primitive reflex patterns—whirling, curling up in the lap, facial grimacing; inability to care for clothing and excretory functions; poorly established respiratory patterns; as well as the embryonic *tonelessness* of muscles and other tissues.[12]

4. *Empathy is Usually Absent.* Almost without exception these children do not have a warm, loving relationship with a parent, with the possible exception of the symbiotic child where it is close but not loving. Nor can they develop good relationships with other adults or children. The exaggerated relatedness to inanimate objects is coupled with the failure to make object relationship to human beings. (You can actually see the absence of normal

emotions.) As Carl Sandburg recently remarked, "Faces often speak what words can never say." Since these children do not converse, they usually tell you their story in the way they look: the face is flat and emotionless, they never smile, their eyes do not sparkle. If they show emotion, it is fear, anxiety, unhappiness—strangely enough, not hate. They have a singular difficulty with expressing hostility. The closest they come to it is the display of irritability and something resembling a temper tantrum when frustrated. As you would expect, with the absence of emotional responsiveness, these children do not play with their contemporaries. They prefer solitary play, or in rare instances play with younger siblings, the play being not without danger to the younger sibling.

5. *Contact with reality is always impaired* and is dependent upon the foregoing. The relationship of the child to his environment is insulated by intellectual impairment and by failure of verbal communication. It is altered by the distorted perceptions of objects and people mentioned above. It is influenced by abnormal motility; and, in addition, there is an element of distance—a blocking of the nonverbal as well as verbal means of communication—that gives the impression of a "wall" and which gives rise to the apparently unrelated, inappropriate, bizarre, impulsive behavior that is autopsychic in origin. The child's concept of reality is especially hard to formulate in this group since we do not have speech, drawing, and painting to help us but in the character of the motility (whirling off into space, curling up in the fetal position), in the methods of play (solitude, inability to make group identifications, violence in sibling rivalry), in gross blocking in parental relationships—all point to essential failure of normal ego development and the resultant flight from reality. This quality of severe impairment of the sense of reality is the most characteristic sign in the psychoses of children.

CONCLUSION

Our experience at the Clinic for the Retarded in the past eleven years has led us to separate out of 1,107 patients some 103 children in whom we believe that a failure of ego development has led to intellectual retardation. This has brought the problem to our clinic. In these 103 children such symptoms as bizarre speech abnormalities, primitive patterns of motility, lack of empathy, distortion of perceptive functions, and loss of reality contact lead us to the conclusion that they are more accurately termed psychotic children. Although the prognosis is not significantly different from that of other retardates, the appropriate nosologic term presents physicians with a challenge: to sharpen one's clinical acumen as well as search for those factors, whether they be molecular, emotional, or social they may some day be modifiable.

76 Clinton Avenue

Bibliography will appear in author's reprints.

Herbert D. Axilrod, M.D.

Atlantic City

Traumatic Rupture of the Bladder and Posterior Urethra*

In these few pages, Dr. Axilrod provides us with a compact textbook on the classification, causes, treatment and sequelae of rupture of the bladder and urethra.

In these days of high speed transportation, industrial accidents and the increased use of endoscopic methods for the treatment of bladder and prostatic lesions, bladder and urethral injuries occur more often than formerly.

Spontaneous rupture of a diseased bladder (carcinoma, deep ulceration or diverticulum) may occur; but spontaneous rupture of a healthy bladder is virtually unknown. Perforation of the bladder by a bullet or impalement through the perineum or rectum in the male or the rectum or vagina in the female should be considered when bloody urine appears at the point of entrance in these types of injuries.[1]

The empty bladder is rarely injured without a concomitant fracture of the pelvis. About 20 per cent of pelvic fractures have associated bladder injuries. In these, the rupture is almost always extraperitoneal, most commonly antero-laterally near the vesical neck. The distended bladder may be burst by a relatively light direct blow. The rupture then is most often intraperitoneal. In these injuries there are frequently symptoms generally associated with any severe injury such as shock and evidence of hemorrhage. Signs of peritonitis may be present and an associated intraperitoneal injury should always be considered. There is generally suprapubic tenderness with rigidity of the lower abdominal muscles. In intraperitoneal rupture the patient is unable to urinate. Pain is accentuated when he tries. He may void small amounts of bloody urine in extraperitoneal rupture. If there is a large amount of bloody urine in the bladder on catheterization the rupture is probably extraperitoneal and not intraperitoneal.

Transurethral prostatic resections and transurethral resection or fulguration of bladder tumors are the endoscopic procedures most often associated with perforated bladders. When the perforation occurs during these procedures there is often suprapubic and epigastric pain even if the patient is under spinal anesthesia.

The primary factor in prompt diagnosis of bladder rupture is to think of it, especially in fractured pelves or in the presence of hematuria following an injury. Many methods have been proposed for establishing the diagnosis. The introduction and recovery of a fixed amount of fluid through a urethral catheter has long been suggested; but this is not adequate since catheters do not always completely empty a bladder. With a large intraperitoneal rent, a

*Read at the Annual Meeting of The Medical Society of New Jersey in Atlantic City, New Jersey, May 18, 1960. This work is from the Urologic Department of the Atlantic City (N.J.) Hospital.

1. Dodson, A. I.: *Urological Surgery*. St. Louis 1944. Mosby, 445, 461, 570 and 583 (1944).

catheter may drain fluid from the peritoneal cavity. Cystoscopy is not satisfactory because often the patient cannot be put in lithotomy position and because of the bleeding, vision is usually poor and a small tear may be missed. Intravenous urograms are helpful, but require an adequate blood pressure. Frequently there is inadequate bladder filling. The procedure is time consuming when there is no real suspicion of a renal injury.

Retrograde cystograms offer the most accurate basis for study. We use 15 per cent sodium diatrizoate (in its Winthrop tradenamed form, Hypaque®). We allow filling by gravity with a pressure of about 20 centimeters of water. These films are best done when x-rays of the pelvic bones are being taken. Some urologists are opposed to extravasation of non-opaque material, however this objection is more than compensated for by the promptness with which the diagnosis is established. The mortality rate in ruptured bladder increases markedly with the time lapse, so swiftness in establishing a diagnosis is essential. Oblique films taken after the bladder has been emptied of the opaque material are important in the detection of extravasation behind the bladder. In extraperitoneal rupture, the urine and opaque material diffuse into the extraperitoneal tissues and remain localized. The pressure of extravasated blood and urine may produce "tear drop bladder." This deformity may also be caused by perivesical bleeding only with no extravasation of urine. In intraperitoneal rupture, the bowel is likely to be outlined by opaque material surrounding intestinal loops.

A Fluorescein® dye[2] has been suggested for the detection of intraperitoneal rupture of the urinary bladder. A litre of 0.5 per cent Fluorescein® is instilled in the bladder. Blood specimens are obtained prior to and 5 minutes after instillation. The specimens are examined under a Wood's light. Fluorescence in the second specimen indicates intraperitoneal rupture. This test of course depends on the rapid absorption of the dye from the peritoneal surfaces. Likewise in intraperitoneal bladder rupture the opaque material instilled for diagnostic purposes may be absorbed from the peritoneal surfaces. We have such a case in which on this basis the performance of a retrograde cystogram resulted in an excretory urogram with good visualization and demonstration of morphologically normal upper urinary tracts bilaterally. (See the figure)

The specific treatment for ruptured bladder is instituted as soon as the patient's shock-like state has been adequately cared for. In extraperitoneal rupture, cystostomy drainage of the bladder is established. If the bladder rent is

Retrograde cystogram in intraperitoneal bladder rupture resulting in excretory urogram.

inaccessible it is not necessary to suture it. In mild cases several Penrose drains are placed for extraperitoneal drainage. If the injury is severe with extensive pelvic infiltration it may also be well to drain through the perineum. If bleeding is otherwise uncontrolled the extravesical space may have to be packed. In intraperitoneal ruptures the rent should be sutured in two layers. This is usually more easily done from the peritoneal side aided by immobilizing the angles of the wound with Allis forceps. Absorbable suture material should be used. A cystostomy tube is then inserted extraperitoneally. If there is an advanced peritonitis in

2. Cipolla, A. F., Khedroo, L. and Casella, P. A.: Surgery, 33:102 (February 1953).

a neglected case it may be best merely to drain the peritoneal cavity. If a small opening is accidently made in the bladder during surgery, this may frequently be closed in two layers and urethral catheter drainage instituted. In accidental perforation of the vesical neck during transurethral surgery, if the perforation is extraperitoneal, urethral drainage and antibiotics may suffice. When in doubt, cystostomy is best. In the surgical repair of ruptured bladder the peritoneal cavity should routinely be opened and inspected for other injuries. Postoperative measures such as blood, fluids and antibiotics are administered as indicated.

TRAUMATIC lesions of the posterior urethra are difficult to differentiate from extraperitoneal rupture of the bladder. This possibility is always to be considered in the differential diagnosis. The bladder is not likely to be distended in rupture of the bladder, but it is in rupture of the urethra. Catheterization cannot usually be accomplished in rupture of the urethra. If it can, the urine is frequently clear.

If the urethral injury is distal to the external sphincter in the region of the bulb there is free urethral bleeding independent of urination. This type of injury is caused most often by straddle injuries with crushing of the bulb against the pubic arch. There is frequently a perineal swelling with subcutaneous hematoma if Buck's fascia is ruptured. Urethrograms may be of help where catheterization cannot be done. Colles' fascia forms a superficial pouch and is attached to the inferior layer of the triangular ligament. It is continuous with the dartos of the scrotum and up onto the abdomen as Scarpa's fascia. This tissue limits the spread of extravasation from the bulbous urethra if Buck's fascia is not intact. The urogenital diaphragm limits the downward spread of extravasation in injuries of the prostatic or membranous urethra so that rectal examination is important. Periprostatic and perirectal bogginess from accumulated blood and urine may be detectable. There may be a high riding prostate if the urethra has been sheared at the prostatic apex by sudden displacement of the bladder.

The treatment of rupture of the urethra involves the principles of (1) diversion of the urine proximal to the injury, (2) re-establishment of the continuity of the urethra and (3) adequate drainage of the extravasated areas. In minor urethral injuries, catheterization may suffice if easily accomplished. Otherwise, urethrostomy or cystostomy with exposure, debridement and suture of the urethra in the perineum in bulbous injuries is the treatment of choice.

When rupture of the posterior urethra complicates pelvic fracture, suprapubic cystostomy should be done with drainage of the perivascular space and the continuity of the urethra should be established with a 24 or 26 F 30 cubic centimeter bag Foley, the severed ends of the urethra being approximated with catheter tension. This can be maintained with a one pound weight. Traction should be maintained for one week and the urethra should be splinted for four weeks. Traction should be maintained on the catheter on a 45 degree angle to avoid pressure on the urethra opposite to the suspensory ligament.[3] Traction sutures, through the bladder neck, brought out through the perineum may be of help in bringing down a high riding prostate. Stricture and impotence are the later complications of urethal injuries.

With an understanding of the principles involved and with the supportive measures of modern surgery excellent results as regards survival and function should be obtained in bladder and urethral injuries.

1616 Pacific Avenue

3. DeWeerd, J. H.: Surgical Clinics of North America, 39:973 (December 1959).

Otto B. Hitschmann, M.D.

Newark

Importance of Correct Diagnosis in Treating Skin Diseases*

Because, by definition, most skin lesions are "superficial" there is a tendency to be casual in diagnostic observation. Everything seems right there on the surface, so to speak. But as Dr. Hitschmann here points out, there is more to dermatologic diagnosis than meets the eye.

Correct diagnosis leading to specific therapy, if possible, has always been the aim of the scientifically thinking physician. Every progress in the basic sciences applicable to medicine will directly or indirectly influence dermatology as an applied healing art. However, the skin is only one organ of the body. Not to recognize skin manifestations as symptoms of a systemic disease would be both poor dermatology and poor diagnostic medicine with obvious consequences for prognosis and treatment. Acute exanthemata, skin manifestations of blood and lymphatic systems, lymphomata and granulomata—to mention but a few—are important diagnoses. A metastatic tumor under the skin may be the complaint that causes a patient to see a doctor too late. The "bullous skin diseases" and the differential diagnosis of pemphigus are other examples of the importance of a correct diagnosis for prognosis and treatment.

A medical and skin history is a valuable diagnostic guide. The well trained dermatologist knows how to read the skin picture. He coordinates it with microscopic and etiologic features familiar to him by previous experience, just as a general pathologist judges macroscopic specimens. Some schools of dermatology believe that clinical examination should precede history taking so as not to bias the objectivity of the examination. The trend towards regional dermatology in some textbooks is of doubtful value. Every experienced dermatologist will remember patients who showed him some lesions of minor significance on an exposed part; then on general examination a severe dermatosis or even epitheliomata were found. The primary lesion of pityriasis rosea may be shown, the generalization overlooked. The diagnosis of lichen planus or of psoriasis with not too characteristic changes on hands or nails has often been missed by incomplete casual examination.

The diagnosis and differentiation of acute disseminate lupus erythematosus from the discoid forms both by clinical features and by the presence or absence of lupus erythematosus cells in the blood will determine treatment and prognosis.

Diagnostic evaluation of a patient with latent syphilis and positive serology is essential to avoid unnecessary treatment of a previously adequately treated case; or to institute treatment if indicated. Verification by the newer highly specific treponema tests of a positive serology without signs or history of syphilis

*Presented at the 194th Annual Meeting of The Medical Society of New Jersey, Section on Dermatology, May 17, 1960, in Atlantic City.

is essential. The significance of a nonspecific positive serology as a possible sign of a systemic disease must not be neglected and makes further diagnostic studies necessary. Syphilis in all forms is still around and should be diagnosed as soon as seen both clinically and by serology; and in acute cases by darkfield examination. The necessity of the 90-day follow-up serologic test for syphilis in every case of other venereal diseases (especially gonorrhea) must be stressed both to doctors and patients as an indispensable measure lest syphilis (masked or suppressed by treatment with penicillin or other antibiotics) be overlooked.

Some cases of urticaria, especially the chronic form, may be cured if the causative agent is recognized and eliminated. The too quickly accepted diagnosis of "psychosomatic" or "neurotic" origin in insufficiently studied patients reflects a supercial or even hostile attitude to the problem.

THE many forms and causes of drug eruptions —from localized or generalized or nodular or even ulcerous—are often a diagnostic problem. The history taking to find a causative agent has to be meticulous, thorough and inquisitive. Acute allergic contact dermatitis, localized or generalized, caused, for example, by cosmetics or occupation, or by local treatment with ointments bought over the counter or prescribed, or from many another cause, will call for keen observation to discover the source. The more new chemicals and various materials are used in our complex culture, the more are the possibilities of sensitization. I recently saw a severe contact dermatitis caused by a perfumed room spray deodorizer. A benzocaine-containing ointment may cause generalized allergic dermatitis not infrequently due to the high sensitizing index of benzocaine. An "id-type" eruption as an allergic manifestation of a tinea cruris or pedis aggravated by penicillin, or too vigorous fungicidal local medication, is not a rarity.

To differentiate an allergic or drug eruption from other inflammatory acute or subacute dermatoses will be important for the use of antihistamines some of which are occasional sensitizers themselves. Antimalarial drugs, antibiotics, and especially steroids have a suppressive action on dermatoses. Their use involves a "calculated risk," which will be properly assessed only if the diagnosis is correct.

Accurate clinical and laboratory diagnosis is imperative for proper treatment of superficial fungus diseases as predicted by Sulzberger and Baer.[1] Tinea capitis, tinea corporis, tinea cruris, tinea pedis, and onychomycosis of the hands and feet have to be confirmed by demonstrating the guilty fungus. This is done by examination under Wood's light for fluorescence of the infected hair or scales, by proper collection of fungus-containing material from the diseased parts for direct examination under the microscope, and by preparation of cultures for identification of the fungi. The trained dermatologist is an expert mycologist and can do this work in his office. He knows how to differentiate fungus diseases from psoriasis, seborrheic dermatitis, intertrigo, alopecias of various origin, moniliasis, syphilis—to mention only few—both through his clinical experience and auxiliary methods. Erythrasma, tinea versicolor, and moniliasis in various localization do not respond to griseofulvin. This highlights the importance of a correct etiologic diagnosis, which will prevent erroneous treatment of those diseases with griseofulvin. Exact diagnosis of susceptible fungus diseases will give preference to griseofulvin treatment in most of these conditions. Griseofulvin has proved revolutionary in the treatment of tinea capitis in children and in curing onychomycosis. The correct differentiation of other dermatoses from fungus diseases will prevent useless erroneous expensive attempts with griseofulvin, and lead to the best treatment.

PEDICULI pubis, pediculi capitis and scabies have sometimes been missed. Although embarrassing for well groomed patients, the proper

1. Sulzberger, M. B. and Baer, R. L.: Excerpta Medica, Dermatology and Venereology, 13:145 (March 1959).

diagnosis and treatment will cure occasionally longstanding complaints and symptoms.

Treatment of benign and malignant skin growths is determined by the clinical diagnosis. The diagnosis should be confirmed or verified by microscopic tissue examination if there is any doubt as to diagnosis or any suspicion of malignancy. In large lesions a partial biopsy may be necessary for correct diagnosis and treatment. As in other dermatologic conditions the biopsy report may be corroborative. The report may clarify doubts; it may correct a mistake in diagnosis by describing the typical picture of another entity. In exceptional cases a biopsy report may be misleading if not coordinated with the clinical picture. The microscopic picture of keratoacanthoma or of pseudoepitheliomatous hyperplasia may for example sometimes be indistinguishable from that of squamous cell carcinoma.

Verruca vulgaris, verrucae planae, mollusca contagiosa, acrochordata on the neck, and many other superficial and benign skin tumors are mainly epidermal lesions. Deep and destructive therapeutic procedures resulting in deep scarring are rarely necessary. Brownish seborrheic keratoses and senile keratoses are not difficult to diagnose and are easy to remove. They must be separated from pigmented nevi because melanocytic nevi are believed to be capable of giving rise to melanocarcinomata. In our carcinophobic age we are often asked what to do with a nevus. We know that 25 per cent, and probably more melanocarcinomata arise without a preceding lesion. As there are no people without some pigmented nevi it is impossible to destroy all nevi. Junctional activity found microscopically in an excised nevus is no proof in itself that this nevus would have developed into a malignant melanoma. We may expect to find junctional activity in flat nevi with speckled pigmentation and an irregular border, further in elevated nevi with a flat pigmented halo, or in nevi with recent changes resulting in an irregular border. These nevi may be excised. So may nevi which are exposed to chronic or repeated trauma, if we believe that this may precipitate or contribute to malignancy. Another even more elective indication for removal of a nevus is the cosmetic one. There is disagreement as to whether surgical removal of a nevus is the only permissible procedure or whether other destructive methods may be used. Decision in each case depends on the personal judgment of the physician and is influenced by the attitude of the patient. In cases of observed activity or clinical suspicion of melanoma, wide and deep excision is absolutely necessary, followed by additional surgery if melanocarcinoma has been found microscopically. And here again a diagnosis of "juvenile melanoma" or "lentigo maligna" may be reported. The former is not malignant. The latter progresses slowly and occurs in aged people who usually do not die of it. This may put the clinician on the horns of a dilemma since experienced pathologists may interpret the same slide differently.

THE histopathologic follow-up of a basal cell carcinoma versus prickle cell carcinoma is of importance both for therapy and prognosis. A basal cell epithelioma does not metastasize. It may be eradicated by surgical excision wide and deep within healthy tissue, or by the time honored dermatologic methods of desiccation and curettage; or by chemosurgery; or by radiation. The squamous cell epithelioma needs all the attention necessary for the treatment of a generally spreading cancer, including higher radiation doses either primarily or postoperatively; observation and care of the regional glands and of the whole body. The biopsy is essential because differentiation by clinical features alone will often be incorrect and may thus endanger a patient's life. Dermatology has advanced far from the descriptive stage of registering symptoms, signs and pictures peculiar to the skin. Nevertheless the "know-how" of seeing and interpreting skin manifestations is the art of the initiate necessary for correct diagnosis and treatment.

846 South 13th Street

L. P. Lapin, M.D.

Bordentown

Successful Long-Term Weight Loss

A patient can abstain from almost any other bad habit, except eating. He can give up smoking, sleeping pills, alcohol, tranquilizers, or staying up nights. But he cannot give up eating. So overweight is America's number one disease. And as Dr. Lapin here shows, weight-control is more a matter of motivation than of calories.

The short-term treatment of overweight is often successful; but for most patients the resolve to lose weight is as fragile and short-lived as all good resolutions. Nevertheless, some do persist in dieting, some do continue to lose weight, some do maintain a weight loss; and these patients, superficially at least, seem little different from those who do not persist. Are there any real differences that can be discerned simply, without extensive and complicated psychologic testing?

To find out, I interviewed 32 patients who had started treatment for overweight eighteen months previously. At that time their treatment had been the one usually tried in general practice. A diet had been prescribed; the common pitfalls of dieting had been discussed with the patients; and dextro-amphetamine sulfate in combination with prochlorperazine had been prescribed as an aid in dieting.

With the inclusion of the tranquilizer, treatment was perhaps somewhat different from the usual; but for the person who overeats, the emotional reaction to dieting, particularly in the early stages, is comparable to that of the heavy smoker who suddenly gives up cigarettes. A pilot study had indicated (and experience with over 150 patients has since confirmed) that this tranquilizer-amphetamine combination generally helps counteract this reaction and so makes dieting easier. Sixteen of these patients were currently under treatment either for overweight or other conditions at the time of the interview. The other 16 discontinued treatment on their own within eight weeks after starting. Patients who were not currently undergoing treatment were asked to come in for a check-up. All patients were personally interviewed for information on their personal and family background, and their attitude towards themselves and their overweight.

On the basis of their eighteen-month weight loss, the patients fell into three general categories: (1) Those who lost weight and maintained their weight loss; (2) Those who weighed the same as they had at the start of therapy; (3) Those who had gained weight.

PATIENTS WHO LOST WEIGHT

Ten patients, all female, succeeded in losing weight and in maintaining a weight loss which averaged 14 pounds or about 9 per

cent of their starting weight. Without exception these patients had sought medical help expressly with the intention of losing weight either because they felt their overweight was unbecoming, or because they thought it was affecting their sense of physical well-being. They had been overweight for an average of 11 years. Nine of the 10 had previously undergone at least one course of treatment. However, previous therapy had been only partly satisfactory, usually because of the subjective effects of the anorectic agents used (generally amphetamines or amphetamine-like compounds) or because of inadequate appetite control. At the start of treatment, the patients had been observed closely to determine the probable causes for their overeating. They were not questioned directly until the follow-up interview, at which time they were asked to describe their attitude towards overweight and to name their "weakest point of character."

From their answers, anxiety or "nervousness" seemed to be a frequent, if not constant problem—one which they clearly recognized. For these patients, overweight served as a convenient focal point for their anxieties. It gave them something objective to worry about and invariably they felt their overweight made them "upset," annoyed, or physically ill. The incidence of overweight in their immediate family (mother, father, siblings, offspring) was relatively low (29 per cent) so one would expect that the family would agree with the patient that overweight was indeed a harmful and undesirable condition and consequently, worth worrying about. For these patients overeating appeared to be emotionally needed, yet at the same time, rationally deplored.

With one exception the patients sought the emotional support afforded both by frequent (or constant) treatment and by medication. Their visits to the physician seemed essential factors in the maintenance of their weight loss. Even though their weight loss could be considered "successful" (in that life insurance statistics indicate their longevity was probably increased) a few stabilized at a point somewhat *above* normal and consequently, their tendency to overeat still plays its accustomed role.

PATIENTS WHO REMAINED THE SAME

ALTHOUGH ten of these 15 patients (2 male, 13 female) had been successful in losing weight initially, they were all within five pounds (3 per cent) of their starting weight at the time of interview. Seven had started treatment on the advice of their physician; one started at her husband's suggestion, and the remainder because of a lack of "pep" or other physical symptoms. Only three started because they wanted to improve their personal appearance. These patients had been overweight on an average of 18 years, and most had undergone treatment before with similar unsatisfactory results. Eight regarded their overweight with equanimity expressing little concern about their condition. With the exception of one patient (who was going through menopause) anxiety when present did not seem to focus on their overweight, even though the proportion (32 per cent) of their immediate family that was overweight was about the same as for the weight-losers.

THOSE WHO HAD GAINED WEIGHT

THE seven patients who gained weight (6 were women) had been overweight an average of about 15 years. Six started therapy for the same reasons as those who lost weight; only one started on the advice of the physician. In contrast to the patients who lost weight, their anxieties seemed primarily concerned with some aspect of their environment or personality other than overweight. Unlike the weight-losers, all these patients had at least one overweight parent and overweight was more prevalent in their immediate family. Fifty-nine per cent of all close relatives were overweight. One would expect that under these conditions, the patient and his family would not be likely to regard overweight as a severe social or physical handicap. Consequently, to both the patient and the family, overweight might easily appear to be an unworthy, inappropriate focal point for anxiety.

SUMMARY

1. An analysis is made of 32 patients who sought treatment for oveweight. The question to be answered was: in what way do successful weight-losers differ from the failures? This series included 7 who actually gained weight; 15 who weighed the same after the course of treatment as before; and 10 who maintained weight loss.

2. The three groups showed no significant differences in ethnic background, education, employment, or weight status of spouses.

3. Motivation appeared to be the main factor. Those who wanted to lose weight for some *specific* purpose and who also used their overweight as a focus for their anxiety seem to be more likely to achieve successful long-term weight loss. Weight loss alone did not decrease their anxiety. The weight-losers' frequent visits to the physician and the fact that they responded to treatment only when prochlorperazine was included with the anorectic agent suggests that they are seeking continued treatment to obtain a possible solution or at least some emotional support for their problems.

10 Prince Street

Benign Gallbladder Tumor

Forty-five patients with benign neoplasms of the gallbladder were observed over 15 years at the Ochsner Clinic. Cholecystographic discovery of these tumors is becoming more frequent, since modern technics may disclose them when they are only 2 mm. in diameter. A fixed radiolucent defect in the opacified gallbladder is suggestive; while it may mimic a radiolucent gallstone, the constant position suggests a tumor, because a gallstone usually moves around. Benign neoplasms of the gallbladder produce no specific manifestations. Indigestion and upper abdominal pain, the most frequent complaints are so common that they are difficult to evaluate. The dilemma facing the patient with a suspected benign tumor of the gallbladder is whether to undergo a cholecystectomy. Malignant tumors may arise from benign tumors. The gallbladders of all 45 patients were removed, and there were no operative deaths and no significant postoperative morbidity. There were 18 patients with adenoma, 15 with papillary adenoma, nine with adenomyoma, two with non-invasive carcinoma, and one with fibroadenoma. Fourteen of the patients had multiple lesions; 21 had gallstones; and in 34 the gallbladder showed chronic cholecystitis.—S. F. Ochsner, M.D., Annals of Surgery, 151:630 (1960).

Psychosomatic Management

According to Staehlin,* most patients with psychosomatic diseases require somatic therapy with major psychotherapy, to which the patient must devote several hundred hours. Where these methods are impracticable, minor psychotherapeutic measures are better than no psychotherapy at all.

The routine adopted in Staehlin's clinic is as follows. The internist can refer to the psychiatrist any patient who seems to need psychosomatic investigation. The psychiatrist gives the patient a 1½ hour interview during which the part played by the organic disease in the clinical picture is established and reported to the referring internist, who is told what psychotherapeutic measures he himself can usefully apply. The patient should receive therapeutic benefit from this long discussion. Some require further talks with the psychiatrist at intervals of weeks or months, but many can be referred back to their internists.

The elaborate mechanisms of special psychiatric testing have no place in this scheme, which is based on complete understanding and cooperation between the internist and psychiatrist. Some excellent results have been achieved; in 1958 the number successfully treated was 140.

*Staehlin, Benedikt: Schweizerische medizinische wochenschrift, 90:177.

Board of Trustees: June 26, 1960

The Board of Trustees met in Trenton on June 26. Among actions taken were the following:

—Authorized the President to appoint a Society liaison representative to the Seton Hall Chapter of the Student A.M.A.

—Confirmed the Society's co-sponsorship of the seminar on psychiatry for general practitioners to be held in Belle Mead this year.

—Concurred in the action of the New Jersey Neuropsychiatric Association in protesting the establishment of a separate Division on Mental Retardation with a non-physician as director. This Division was established by its Board of Control within the State Department of Institutions and Agencies.

—Authorized publication in the *News Letter* of material relating to the differences between nursing homes and boarding homes; also asked the Executive Officer to acquaint the membership with the study to evaluate diagnostic information on cardiovascular renal deaths being made in cooperation with the National Heart Institute and the National Office of Vital Statistics.

—Received a committee report on the proposal that there be worked out a method of payment by Blue Shield (MSP) for diagnostic radiology and pathology in outpatient departments. The Trustees concluded that "no such method for payment by Blue Shield is acceptable because radiologists and pathologists are under contract with hospitals to render hospital services."

—Heard a report on the work of the special committee on criminal responsibility and concurred in the following statement which had been approved by the New Jersey Neuropsychiatric Association. That:

> "This committee, recognizing the advances in scientific knowledge concerning man's mind and his mental and emotional states, supports the objective of the New Jersey Neuropsychiatric Association to achieve recognition on the part of the Courts and the Legislature of New Jersey of the status of this knowledge, and to effect an amelioration of the application of the M'Naghten Rule in conformity therewith."

Attorneys representing a medical group requested a statement from the Medical Society on the "Kintner"-type association, under the proposed regulations of the Internal Revenue Service, with regard to income tax advantages. Mr. Backes reported that a favorable statement by the Medical Society at this time might unduly involve it in a tax matter between IRS and certain physicians in which the Society could be of small assistance. A reply was proposed, and with slight change, was approved as follows:

> "In view of the fact that Internal Revenue Service has published nothing more than Proposed Regulations (December 24, 1959) which have been, and can be, criticized from the point of view that they do not clearly distinguish between associations and partnerships for tax purposes; that it is anticipated that final regulations, which may be in substantially different form, are expected to be published shortly; that the creation of an association under any of our existing statutes or judicial determinations would not meet the criteria for such tax advantage without substantial change; The Medical Society of New Jersey, through its Boards of Trustees, deems it inappropriate at this time to make any general statement concerning the 'Kintner' problem."

—Mr. Backes commented on the unfavorable decision in the Falcone case which declared that the action taken by the Middlesex County Medical Society (in excluding Dr. Falcone from active membership) was void and of no effect. The Court ordered the Society to admit Dr. Falcone to full membership. In accordance with the January action of the Trustees, "that an immediate appeal be made if an unfavorable verdict is received," steps have been taken for the appeal, and the order of the Court is stayed pending a final determination of the Appellate Court.

Dr. Ware moved—seconded by Dr. Kaufman, and carried—that legal counsel proceed with the appeal and, with the cooperation of the President and Chairman of the Board of Trustees, be given authority to call in additional counsel if it seems that the Society's advantage will be served.

—The recommendation of the Board of Trustees for discontinuance of diagnostic riders was rejected by the House of Delegates. The following recommendation of the Reference Committee was adopted:

"That study be continued by the Hospital Association and the Medical Society to evolve a method for payment by Blue Shield for diagnostic x-ray and diagnostic pathology done in the outpatient department of the hospital at the direction of the attending physician."

The Board agreed that this had already been covered earlier in the meeting.

—In response to the request of the Board of Trustees that the House of Delegates direct the Board and the Council on Legislation concerning an amendment to the School Examination Law (1959—S-147), a recommendation of the Reference Committee was adopted to the effect that the legislation be reintroduced.

Upon motion by Dr. Ware—seconded by Dr. Kaufman, and carried—the recommendation was referred to the Council on Legislation.

—The following resolution was adopted by the House of Delegates:

Whereas, with the introduction of Assembly Bills 556, 612 and 60 in the New Jersey State Legislature it becomes necessary to resist the invasion by legislative enactment of the freedom and rights of the members of the medical profession; and

Whereas, the Bergen County Medical Society is on record as opposing Assembly Bills 556, 612, and 60, and all similar legislation; therefore be it

Resolved, that The Medical Society of New Jersey continue to oppose these bills and any similar legislation which encroach on the free practice of medicine by non-medical groups or individuals.

Upon motion by Dr. Wegryn—seconded by Dr. Buchanan, and carried—the resolution was referred to the Council on Legislation.

—Two resolutions on Technical Services were referred by the House to the Board of Trustees for action, with power to act.

(Proposed amendment to Medical Practice Act—45:9-21 (k) underlined):

a. *From the Board of Trustees*:

"A chiropodist, professional nurse, medical or x-ray technician, or a graduate physiotherapist, masseur, electrotherapist, or hydrotherapist, while operating in each particular case under the specific direction of a regularly licensed physician or surgeon."

b. *From the Radiologic Society*:

"A chiropodist, professional nurse, medical technician, x-ray technician operating in a radiologic installation maintained by a physician or surgeon, or in a radiologic installation maintained by a hospital, or a graduate physiotherapist, or hydrotherapist, while operating in each particular case under the specific direction of a regularly licensed physician or surgeon."

Dr. Allman moved—seconded by Dr. Greifinger, and carried—that proposed amendment "b." (from the Radiologic Society) be approved.

Dr. Kaufman moved—seconded by Dr. Allman, and carried—that the approved proposed amendment (b.) be referred to the Council on Legislation for introduction of the necessary legislation.

—The following resolution was adopted by the House:

Whereas, a recent ruling by the Superior Court of New Jersey has held that the transactions, records, and minutes of these bodies (Judicial Council and Judicial Committees) are not privileged, but are subject to subpoena and scrutiny by other than the Judicial Council and the various Judicial Committees and their attorneys; therefore be it

Resolved, that the Board of Trustees of The Medical Society of New Jersey refer this problem to their appropriate committee, and also to their legal counsel, for the purpose of exploring the possibility of securing suitable legislation to preserve the efficacy of this important function by granting the immunity of privilege to all procedures of the Judicial Council and the Judicial Committees of the various component county societies.

Upon motion by Dr. Greifinger—seconded by Dr. Ware, and carried—the resolution was referred to the Council on Legislation and to Legal Counsel.

—The following resolution was adopted by the House:

Whereas, by process of statute and regulations imposed by the Public Health Council, a physician is not now eligible to occupy the position of Health Officer without a license issued to him by the Public Health Council, which license is not obtainable without:

"Satisfactory completion of two years of full-time working experience in a position requiring administrative responsibility in a health department or some other public health organization approved by the State Department of Health for such experience.

OR

"Satisfactory completion of one year of full-time planned working experience with the State Department of Health."

Resolved, that the Legislature be requested to pass an appropriate amendment to the statute entitling physicians duly licensed in this state to serve as Health Officers without further license.

Upon motion by Dr. Kaufman—seconded by Dr. Allman, and carried—the resolution was referred to the Council on Legislation.

—The "pilot plan" for Eye Care on a Funded Basis, proposed by the Special Committee on the Conservation of Vision and approved by the Board of Trustees, was referred back by the House of Delegates for further study. The House directed that the "plan" be published in the JOURNAL for study by the membership before implementing action be undertaken. (See page 499, August issue)

—The Secretary reported a vacancy on the Committee on Publication due to the recent death of Dr. Joseph E. Mott, Paterson, who had been elected by the 1960 House of Delegates to membership on the committee for a three year term. Four candidates were nominated and Dr. Frank Rosen of Essex County was declared unanimously elected to the office until the next Annual Meeting.

—A rule dealing with impartial medical witnesses has been drafted for consideration at the fall Judicial Conference. The plan is to be offered as a pilot study in four counties (Essex, Union, Morris, and Warren), and the special committee feels it is a forward step. It is hoped that the Judicial Conference will accept the rule, and approve the pilot study and that both will be accepted by the Supreme Court. It was decided to authorize Mr. Backes to attend the Judicial Conference to answer questions from the medical standpoint.

—A second rule is being drafted to cover the malpractice situation. It will require the establishment of committees in each county composed of two physicians and one lawyer to evaluate the merits of proposed actions in the field of professional liability for physicians. This plan is proposed to operate on a trial basis in four counties. The Board approved this portion of the report.

The Board was informed that when copies of the final drafts of both rules are available they will be distributed to the Trustees for review.

—A joint meeting of the special study committee, the Committee on Medical Defense and Insurance, and a representative from the American Mutual Liability Insurance Company was held on June 21, 1960.

The Commissioner of Banking and Insurance has refused to approve a Group Policy. The contract has been revised to provide professional liability insurance on an *individual* policy basis. This offers the same coverage at the same rates under a Group Plan. As urged by the House of Delegates, a "libel, slander, and defamation of character" endorsement to the policy has been provided covering an individual acting within the scope of his duties as an officer or employee of the State Society or a component society, or as a member of a committee of the State or component society, or an accredited or licensed hospital. Coverage will be made available for physicians, registered nurses, and qualified technicians employed by members covered by American Mutual.

The initial premium for the "libel, slander, defamation of character endorsement" will be 50 cents per member for the first year. On the anniversary date of November 1, 1961, the premium will be determined by applying 50 cents to each member not insured by American Mutual. No charge will be made for members insured by American Mutual. As participation in the plan increases, the premium will be reduced. The State Society will be billed and will pay the premium for the liability coverage and for the "libel, slander, defamation of character" endorsement.

The company has requested the Society to furnish a definition of "surgeon"; and the special committee recommends that this task be assigned to the Committee on Medical Defense and Insurance.

The report of the Special Committee on Professional Liability Insurance Study was accepted and the committee was discharged with thanks for a job well done; and implementation of the program, including supplying the company with a definition of "surgeon," was assigned to the Committee on Medical Defense and Insurance. The President was authorized to sign the contract with American Mutual.

—Dr. Donnelly reported that his special committee had drawn up a brief of arguments opposing the issuance of a separate Blue Cross Rider for diagnostic services. In view of the attitude of the Hospital Association, it is felt that no alternative remains except for the special committee to appear before the Commissioner of Banking and Insurance. Dr. Donnelly asked the Board for specific instructions.

It was agreed that the President inform the Hospital Service Plan that the Society has been unable to reach an agreement with the Hospital Association, and that if H.S.P. wishes to present its rider to the Commissioner at this time, the special committee will be activated to appear before the Commissioner to oppose it. Our special committee was then authorized to proceed in accordance with the directive of the House of Delegates when and

if the Blue Cross Rider is submitted to the Commissioner of Banking and Insurance.

—In an effort to improve the attendance at section meetings, the section officers and the Committee on Annual Meeting have agreed to a combined program in 1961 on a trial basis. Seventeen sections will combine for presentation of eight programs; three sections will present individual programs. Each meeting will schedule a 30-minute break mid-session for visiting the exhibits and for the election of officers. This plan was approved.

—It had been suggested that the attendance at the annual Dinner-Dance might be increased by having the affair on Monday evening instead of Tuesday, and the Board concurred.

—The Mills Bill, H. R. 12580, to appropriate funds for medical expenses of the medically indigent through amendment of the Social Security Act, passed the House this past week. The A.M.A. has requested State Societies to notify their Senators that organized medicine is *not* opposed to the bill in its present form but is strongly opposed to any Forand-type amendment. Dr. McCall was authorized to send a letter to Congressman Mills thanking him and stating why it is a good bill; and that a copy of the letter with a covering letter urging support of the bill in the Senate be sent to the New Jersey Senators.

—New Jersey will have 56 delegates to the White House Conference on Aging in Washington in January, 1961. It was decided that the Board send a letter to the Governor inquiring as to how the Medical Society may assist him in the selection of New Jersey representatives, indicating that the Society would be pleased to submit names of those qualified to represent medicine.

—For information of the Board, in lieu of the official report of the A.M.A. Delegates which had not yet been received, Mr. Nevin reported the following actions of the A.M.A. House of Delegates on New Jersey items:

Aeromedical Transport Service—Strongly commended by the reference committee and adopted unanimously by the A.M.A. House of Delegates.

Fund Raising Organizations—House adopted recommendation of the reference committee, "that this resolution be referred to the Board of Trustees for study and disposition."

Foreign Interns (Passaic Resolution)—House adopted reference committee's recommendation that this resolution "be not approved."

Re-Evaluation of Approved Intern Program (Bergen Resolution)—House adopted reference committee's recommendation that this resolution "be not approved."

Vice-President. William F. Costello, M.D., of Dover, New Jersey Delegate to the A.M.A., was elected Vice-President of the A.M.A. at the closing session of the House of Delegates.

Dr. Allman moved—seconded by Dr. Kaufman, and carried—that a letter of congratulations be sent to Dr. Costello.

—Received from the chairman of the Advisory Committee to the Woman's Auxiliary, Dr. Fritts, was a copy of the proposed program for the Woman's Auxiliary for 1960-61. The committee recommended approval of the program as presented with two exceptions:

1. The chairman recorded himself as not favoring item 7 under Health Careers—To communicate with pharmaceutical houses and industry asking for financial aid in setting up a fund for health careers scholarships for the state.

Dr. Ware moved—seconded by Dr. Greifinger, and carried—that item 7 under Health Careers be stricken from the program.

2. The committee recommends that item 10 under Public Relations be referred to the Council on Public Relations for its evaluation and recommendation—A public relations program from the medical viewpoint on care of the aged be presented in October with representatives from state organizations being invited to be sponsored by The Medical Society of New Jersey.

This item was referred to the Council on Public Relations for evaluation and recommendation. Then the Auxiliary program was accepted as amended.

—With the renewal of the Medicare Contract, and in support of advance funds to Medical Service Administration, fiscal agent for the Society in the administration of the program in New Jersey, the Government requires the furnishing of a bond. Dr. McCall recommended that the proper officers be authorized to sign the necessary papers for the bond. A motion to that effect was carried.

Woman's Auxiliary

PROPOSED PROGRAM 1960-61*

1. *A.M.E.F.*: To raise funds for A.M.E.F. through county projects; and to increase individual contributions.

2. *Annual Reports*: To prepare accurate reports of the activities and accomplishments of all county auxiliaries and to present these written reports to the membership.

3. *Archives*: To maintain a systematic record of activities. To inform county auxiliaries what should be kept as permanent records on a county level.

4. *Arts and Hobbies*: The activities of this committee will be established upon the assumption that the cultural pursuits of physicians' families represent a common bond between the medical profession and the lay-community at large. Painting and sculpture, when expressions of such cultural pursuits, are deserving to be exhibited publicly.

Exhibits will provide a source of pride and admiration in the minds of our friends, and at least an implied identification with "culture, academics, and the arts." This is a positive form of public relations.

Theme: It is proposed that the usual Woman's Auxiliary State Art Exhibition for 1961 stress "The Physician's Family as a Source of Creative Art." In addition to the usual entries by members of the Auxiliary, non-competitive contributions by the physicians themselves should also be displayed. Acknowledging the disparity in doctor population from county to county, but conceding the necessity for simplicity and control where a new concept is to be placed into operation, contributions would be limited to one painting or one piece of sculpture from each doctor who wishes to participate. Each physician entry will receive an appropriately inscribed certificate of appreciation for his participation in this public relations activity. As a concession to the public relations effect, which is primarily desired, and to the fact that works of art by physicians are judged competitively each year at the National Convention, these entries will not be awarded prizes.

5. *Bulletin*: To secure subscriptions to the National *Bulletin*.

6. *Chronic Illness and Aging*: Cooperation with The Medical Society of New Jersey in the dissemination to the aging of Medical Society approved information concerning facilities currently available in New Jersey communities for handling the problem of chronic illness. With permission, make a survey in each community of the county of existing institutions and agencies offering assistance to the aging in various phases of chronic illness. To disseminate data on facilities available to the aged.

7. *Civil Defense*: To cooperate with The Medical Society by setting up civil defense exhibits in public libraries, continuing support of the civil defense program, providing counties with home preparedness kits, encouraging an interest in fall-out shelters for homes, and by cooperating—with Medical Society approval—with New Jersey Civil Defense Committee.

8. *Convention*: (1) To arrange the Auxiliary's Annual Meeting; (2) To conduct a golf tournament for Auxiliary members; and (3) To sponsor an Art Exhibit at the Annual Meeting, exhibitors to be Auxiliary members and members of The Medical Society of New Jersey.

9. *Health Careers*: Our program is:

(All expenses incurred by the second and third items will be assumed by the Auxiliary.)

(1.) To collect and disseminate materials on allied health careers in high schools and in the State Office of the Auxiliary.

(2.) To place the *Health Careers Guidebook* in the hands of the guidance directors of high schools.

(3.) To encourage guidance directors to make health information available to interested students.

(4.) To continue to promote the formation of "Future Nurses Clubs" in high schools and to encourage nurse scholarships.

(5.) To establish a speakers bureau on allied health careers and to make this information available to high schools in planning their programs.

(6.) To explore the possibilities of establishing a state scholarship applicable to: nursing, medical technology, medical social worker,

*At approved by the Board of Trustees, June 26, 1960.

social worker, dietetics, physical therapy, occupational therapy, medical record librarian, speech and hearing therapy, x-ray therapy or any other career pertaining to the health of our state.

(7.) To request each county careers chairman to plan one program during the year in which high school students, educators, hospital personnel, and health organizations are invited.

(8.) To continue to list all available scholarships in the state for health careers.

10. *Legislation*: To write to county chairmen on legislation asking them to have telephone committees standing by, so that when requested to act on legislation by the Medical Society, the telephone committees will be able to call each member of their county auxiliary without delay. All Auxiliary members, especially chairmen on legislation, should keep informed; to discuss issues only when called upon by The Medical Society of New Jersey.

11. *Medical Student Loan Fund*: To raise funds for the Medical Student Loan Fund of The Medical Society of New Jersey and cooperate with the committee of The Medical Society of New Jersey upon request. To promote memorial donations through the efforts of the county chairmen and to encourage individual and group contributions. Goal: 100 per cent cooperation from the counties.

12. *Mental Health*: To cooperate with the Committee on Mental Health of The Medical Society of New Jersey. *Aim*: Know your local mental health facilities. Every county auxiliary should devote one meeting this year to a mental health program and visit nearby State Hospitals, as approved by county medical society.

13. *Organization*: To establish auxiliaries in Morris and Sussex Counties upon the approval of the medical societies of these counties. Local auxiliaries are expected to devise means to encourage wives of young members of The Medical Society of New Jersey to join the county medical auxiliaries.

14. *Press and Publicity*: To send meeting announcements and reports of Auxiliary activities to county press and publicity chairmen. It is important to define clearly and crisply the rules for Press and Publicity contest and to arrange for press book judging at the Convention.

15. *Program*: At the Annual Meeting recommend a change in program. Instead of the projection of color slides, prepare a display of county projects. It is also intended to arrange appropriate programs for Board meetings.

16. PUBLIC RELATIONS

(1.) For Community Service to cooperate with the Special Committee on Conservation of Vision of The Medical Society of New Jersey in the 1960-61 Eye Health Screening Program.

(2.) To cooperate on county level with health organizations not already represented by special committees, such as: Heart Association, Tuberculosis and Health Association, and Red Cross (individually or collectively—if approved by the county medical society).

(3.) To secure health films from the A.M.A. for any approved organization requesting them.

(4.) To have a film showing in the Trenton office.

(5.) To distribute to approved organizations, the list of films printed in our folder from last year.

(6.) To continue to foster health education meetings at county level using only programs, speakers, and films approved by county medical societies.

(7.) To cooperate with the Council on Public Relations of The Medical Society of New Jersey in any project it may suggest.

(8.) To cooperate with the Committee on Health Careers and to help emphasize its approved program.

(9.) In cooperation with the Woman's Auxiliary to the American Medical Association, to emphasize the health care of the aged program, if approved by the county medical societies.

17. SAFETY

(1.) Communicate with all county presidents and safety chairmen requesting them to include a safety program in their year's planning; suggesting a speaker and films, in any field of safety such as driving, hazards in the home, and others.

(2.) Obtain from the National Safety Chairman ,material on safety programs to follow this year; or stress, as soon as possible, so that we can set up our State program.

(3.) Seek permission to allow county chairmen to write the high schools who have students' driving training programs to show films emphasizing careful driving.

(4.) Communicate with local organized groups such as church, PTA groups, etc., to show films and distribute literature, with reference to hazards in the home and safety procedures to follow.

(5.) To distribute as much of the literature locally where it will be seen, such as libraries, hospital lounges, doctors' offices, waiting rooms and the like. It may be possible to persuade theatre managers or owners locally to show these films.

18. *Widows and Orphans*: To seek approval from county medical society or medical advisors to encourage membership in the Society for the Relief of Widows and Orphans of Medical Men in New Jersey.

Arthritis Booklet Available

Strike Back at Arthritis is a booklet for the physician with arthritic patients prepared by the United States Public Health Service in collaboration with the National Foundation of Arthritis and Metabolic Diseases, and the Arthritis and Rheumatism Foundation. You may buy it from the Superintendent of Documents, United States Government Printing Office, Washington 25, D. C. at 40 cents per copy.

The State Department of Health believes the physician will find this publication valuable in his treatment of arthritic patients.

Obituaries • • •

DR. JOSEPH J. CARTISSER

Death came on August 8 to Dr. Joseph J. Cartisser, a member of the Sussex County Medical Society. Dr. Cartisser was only 53 years old at the time of his death. A 1930 graduate of the College of Physicians and Surgeons (Columbia University), Dr. Cartisser interned in Jersey City and then engaged in private group practice in Bayonne. In 1943 he opened an office in Sergeantsville and became active in the affairs of the Hunterdon County Medical Society, serving as president of that component in 1940. The following year he moved to Stanhope where he died at his home. He had been president of the Stanhope Rotary Club and was surgeon to the Stanhope Fire Department. He also had served on the local Board of Education.

DR. ANTHONY J. CONTY

Dr. Anthony J. Conty, for many years a member of our Society's Finance and Budget Committee, died on August 1, in New York City. Born in that city in 1890, he received his M.D. degree at Bellevue in 1913. After internship, he did graduate work in eye-ear-nose-and-throat at New York Postgraduate Hospital. In World War I he served as chairman of the Union Town Selective Service Board.

Dr. Conty maintained his office for the practice of ophthalmology and otolaryngology in Union City. He had served as chief of that department at the North Hudson Hospital. He served the Hudson County Medical Society in many capacities and some years ago, he was president of that component. He was an FACS as well as a Fellow of the American Academy of Ophthalmology and Otolaryngology.

DR. JOHN A. FEDOR

At the untimely age of 37, Dr. John A. Fedor died on September 6 in Trenton. A graduate of the Hahnemann Medical College, class of 1947, Dr. Fedor served in the Army and was affiliated with both Mercer Hospital and Trenton General Hospital. A general practitioner, Dr. Fedor was a member of the Mercer County Medical Society and active in numerous civic and service organizations in the Delaware Valley area.

Open Discussion on Medical-Surgical Plan

194th Annual Meeting

May 14, 1960

The discussion on the Medical-Surgical Plan was convened at 4:00 p.m., Dr. Royal A. Schaaf presiding.

PRESIDENT BOWERS: In the past few years there has been an open discussion on the Medical-Surgical Plan. This is the time for you to get up and discuss it. This has to do mostly with your own personal problems. It does not refer to such policy problems as diagnostic riders, which will be discussed before the Reference Committee, and then be brought before the House for action. This is *not* the place to discuss the diagnostic riders. This is the place, however, to bring up other questions relative to the Medical-Surgical Plan.

At this time I turn the microphone over to our good friend, the President of the Medical-Surgical Plan of New Jersey, Dr. Royal Schaaf.

DR. ROYAL SCHAAF: Thank you, Dr. Bowers. It is a pleasure on behalf of the Governors of the Medical Service Administration and the Trustees of the Medical-Surgical Plan of New Jersey to welcome you to this annual meeting where you review our action. I now would like to take this opportunity to present a few of our people with whom you have had contact over the years. It is well for you to know to whom you are speaking or to whom you are writing. You will find that they are all human beings and kindly people. Mrs. Nugent is the Administrative Secretary of the Medical Service Administration and has just completed ten years of loyal and competent service. Will you take a bow, Mrs. Nugent, please? (Applause) Incidentally, Mrs. Nugent is the sole employee—you can spell it either way, soul or sole—of the Medical Service Administration.

I would next like to present Mrs. Barbara Jennings who has been with the Medical-Surgical Plan of New Jersey for the last eight years. Without her competent guidance, most of us would flounder. Mrs. Jennings. (Applause)

Here is our public relations adviser and counsel. Actually, he is on the staff of the Hospital Service Plan and doesn't deal directly with this Society, but he has rendered very valuable and splendid service to us. I wish Mr. Lyon to take a bow. (Applause)

Then here are Carl Nacca, one of our medical advisers, and Dr. Rothgesser and Dr. Kimmel; our counsel, Mr. William R. Vanderbilt; Dr. Borsher, a Trustee and now consultant to the Plan; Mr. Durgom, Vice-President of the Hospital Service Plan, who has done yeoman service in the sale of our product and the development of the content of our contracts. Next comes Harry Comando, a former Trustee of the Plan and now a member of the staff handling physicians' relations. You know how effective he is when it comes to straightening out minor details and major ones too. Finally, we have Dr. Alfano, the present Medical Director, who is terrific. Dr. Alfano. (Applause)

I am assuming that you have read the first report which was published with the annual reports.

There are two important activities of the Medical Service Administration. One is the conduct of the Newark plan for the care of indigent and medically indigent persons. If you look briefly at that you will see that it's about stationary in the number of claims that we have and the amount of money we pay. Note also our experience with Medicare. I invite your attention to the large amount of work which has really been done in this field. The Medical Service Administration was responsible for the payment of $1,762,507 to the physicians of New Jersey in the past year. I call attention to that particularly because on frequent occasions the function of the Medical Service Administration has been presumed to be limited to the payment of Newark physicians for the care of the indigent and medically indigent. This is a misconception of our function. Without Medical Service Administration, either The Medical Society of New Jersey would have to conduct this work itself, find a commercial insurance company to do it, or have direct payments for Medicare bills made by the Government from Washington. We think, with pride, that this has been an efficient service and has been of great value to the doctors and personnel of the Armed Services.

With those brief comments on Medical Service Administration, I next invite you to consider Medical-Surgical Plan itself.

We have had a very prosperous year and the prospect is reflected in the payment of just short of 500,000 claims for a total amount of just under thirty million dollars paid to physicians of the State. This represents an increase in enrollment of 151,000 persons in the year. When one considers the enrollment a years ago and the intensely competitive character of prepaid sickness insurance field, you realize that a gain of 150,000 people in the year is a very substantial accomplishment and we are gratified for the support the people of New Jersey are giving to the plan.

To the Board, one of the most gratifying things is the maintenance of the roster of participating physicians. We have nine-tenths of one per cent more this year than we had last year; and we have had a number of physicians, who left us for one reason or another, who are now back as participating physicians. We are still concerned about the relative scarcity of the specialist obstetrician and by some of the other specialists like neurosurgery and chest surgery. But they are gradually coming in in increasing numbers and we are hopeful of further participation by them.

The physicians' relations situation is better now than it has ever been and we credit that to two causes: one is that our payments are more nearly equitable to the service rendered; and second, we have in Dr. Comando, whose time and attention is devoted largely to contact with physicians, a man who knows the Plan very thoroughly and who has the time to devote to your problems, if and when they arise.

At the meeting of the House of Delegates on March 13th one of the radiologists said that the Medical-Surgical Plan had been requested to do many things on many occasions, to none of which we had responded. This is *not* quite a fair criticism of the Board. There are a few things which we have been unable to accomplish. For a long while specialist obstetricians have urged us to remove pre-natal care as an eligible benefit from the contract and we repeatedly tried to do that with the Banking Department without success. In the 1956 contract we had to retain that feature because the Banking Department considered it a diminution of benefits to delete it.

Another thing that we were asked to do to protect the specialist was to remove consultation from the contract. Again we encountered difficulty with the Banking Department because it was regarded as a reduction in benefits and the Department is adamantly opposed to any such diminution. However, we are developing a new contract and we will again endeavor to delete pre-natal care and consultations.

We have been urged to waive the income limit in cases where a subscriber or a claimant has insurance in more than one company besides Blue Shield. We have been asked to waive the income limit when third-party accidents are involved. We have taken up both of these proposals with the Department of Banking and Insurance and we have met firm opposition from the Commissioner but we are still negotiating for those two corrections.

You certainly will be interested in some of the problems of the Plan and one of the present problems which is of greatest concern to the Plan Board is the pending legislation which directly or indirectly would affect Blue Shield and indirectly will affect Blue Cross.

I'll speak first briefly of Assembly Bill 555, which in effect would change the present complexion of the Board of Trustees of Hospital Service Plan so that it would have perhaps six public directors who would be appointed by the Governor, subject to ratification by the State Senate. This would change the present complexion of the Board so that it no longer would be controlled by a majority of hospital trustees and hospital directors, which parallels the Medical-Surgical Plan Board where the majority of the Board legally must be composed of physicians.

We feel that the Medical Society should join the Medical-Surgical Plan and the Hospital Plan in opposing this legislation because it would be injurious to the Hospital Service Plan and might even lead to disruption of the Plan because of the dissatisfaction on the part of the hospitals. The hospitals' attitude toward Hospital Service Plan is very much the same as the attitude of the doctors toward the Medical-Surgical Plan.

Three other bills are of great concern to the Medical-Surgical Plan itself. One is Assembly Bill 60 that would change the requirement that there be at least 51 per cent of physicians in each county in which the Plan does business in order for a non-profit medical plan to function. It would take the control out of the hands of physicians and it would lead to invasion of the field by groups like H.I.P. in New York and like the Kaiser Plan in California and similar organizations. It would disrupt the free choice of physician, which is basic in the Blue Shield contract at the present time. We understand that The Medical Society of New Jersey is going to oppose A-60, and we hope they do so successfully.

We are also concerned with A-556 which, if you divest it of its window-dressing, would give the Commissioner of Banking and Insurance the right to control physicians' fees. That, of course, would ruin the Plan. The Medical Society of New Jersey took a very active part in opposing the bill and the Medical-Surgical Plan has sent a memorandum to the Governor, to the Banking Commissioner, to the Assemblymen and to others setting forth in clear terms our objections to the bill. That was reinforced by a similar letter from Dr. Bowers on behalf of The Medical Society of New Jersey, which was sent to all legislators. Apparently that created a great deal of concern among legislators and we rather believe that this bill will remain in committee. But it must be carefully watched and if it is brought to the floor every effort must be made to induce our legislators to vote against it.

There are two other bills, 611 and 612. We are in a very difficult position here because they are parallel bills; one affecting Blue Cross and one affecting Blue Shield. Blue Cross is eager to gain legal authority to offer group ratings or "experience ratings," as it is commonly called. Blue Shield Board has agreed *not* to oppose that provided it was permissive and that we could accept it or reject it if and when the time came. That was the agreement last year. This spring on behalf of the Department of Banking and Insurance these two bills were introduced. And in addition to permitting our Plan to offer experience ratings and charging us two cents per person insured in order to pay the cost of the work of the Department, they put in Section 7. This is most restrictive. It would place complete direction of the Plan in all its aspects in the hands of the Commissioner of Banking and Insurance.

Although Blue Cross has accepted this restriction and is still urging that the legislation be passed, our Board is adamantly opposed to it because we would be yielding our present control to the Banking Department. Not only would it be in the matter of fees, but it would be in every other aspect of policy. It is a very carefully worded bill and unless one is used to seeing the machinations of the Department to gain control of the Board and policies of the Medical-Surgical Plan, one wouldn't realize the dangers of this particular bill. So we have prepared another round robin to send out to the Banking Department, to the Governor and to the legislators expressing our dissent and the reasons for it. We hope that all of you are going to be watchful of these bills and to urge your legislators to oppose them if and when they come up.

I will ask Mr. Durgom to tell you about the major medical expense coverage which is being investigated by a number of the county societies. There are certain risks in that and all of you should be aware of what those are.

Mr. Durgom: Major medical insurance is one of the most interesting developments in this field during the past ten years. It was prompted by the economy in which we are living. It was encouraged particularly by the upper income group which does not find itself covered in an inclusive basis. In the absence of any overt step by service plans to establish a full benefit program, regardless of income, there has developed this desire at "management" level of companies so that they can, in catastrophic illness, have broad coverage. Unfortunately, such coverage in terms of dollars reaches an astronomical proportion when you think in terms of $10,000 being made available. In principle, this is laudable. In practice it can eventually destroy the economics of the distribution of health care. My comments do not reflect on any of the fine group insurance companies. Nor do I say that the program is entirely wrong in its objective. My comments are based on the fact that the program is getting out of hand in the insurance companies' experiences and as very directly related by them in reported documents.

Twenty million people are now covered by major medical insurance across the country. That is about one out of every six holding basic coverage in the voluntary movement. While most of this was originally developed among the "management" level; it has gone down into the "labor" level where in the change for fringe benefits we reach that "silk stocking" desire to have some money in pocket beyond what the basic coverage is intended to provide. As a result, it does affect Blue Cross directly and, indirectly, Blue Shield in this particular situation as it's come to hand; namely, that there is under consideration by some medical society county groups (particularly, I understand Essex County, Bergen and Passaic Counties) exploring major medical insurance as an additional benefit not an integrated part of the Blue Cross coverage which they now hold.

This particular program is unusual in the sense of the general pattern of the major medical programs across the country. The more usual plans generally are interposed in terms of the "package" of Medical-Surgical Plan and Blue Cross whereby the major medical is an *added benefit* after Medical-Surgical and

Blue Cross drop off in the sense of the long-term illness. This particular major medical program under consideration by the medical groups is one that has nothing to do with physicians' fees at all. It is strictly focussed on the hospital end of bills for illness, covering private duty nurses, differential and private accommodations and drugs at the three major areas.

The insurance companies agree to pay over and above the first $500 an amount up to $10,000 on an 80-to-20 per cent co-insurance basis; meaning that if a hospital bill were $2000, after the first $500 the insurance company on the next $1500 would pay 80 per cent or $1200; and the insured would simply underwrite the other 20 per cent, namely, the $300.

Blue Cross is all-inclusive full coverage for 120 days for everything except private duty nurses; in fact, and for just a small marginal difference between semi-private and private room rates, whereas drugs are quite comprehensive under the Blue Cross contract.

If there were such a bill of $2000 in charges and Blue Cross, say, covered $1800 of it and there were $200 for nurses' fees, the person would be exposed under the Blue Cross program to pay just the $200 for private duty nursing. But, with this major medical he would collect from the insurance company over and above the first $500, notwithstanding that Blue Cross covered $1800 and he would collect for the remaining $1500 exactly 80 per cent of the bill, which would be the $1200 I mentioned. In other words, in that illustration the doctor will have had money in pocket for the overlapping duplication of benefit payment occasioned by the insurance company.

With that brief analysis, there is posed the problem to Blue Cross of what to do with the medical groups enrolled under Blue Cross. There are over 4000 doctors across the State enrolled in Blue Cross in New Jersey on a group arrangement. We have a rule, developed over years of experience, that we will *not* continue any group after there has been determined an "overlapping of dual coverage." It means, therefore, that we will find it necessary, not because it's the medical profession, but because of the consistency as a public policy and not being discriminatory, we will find it necessary to terminate the medical groups enrolled in Blue Cross on the group basis.

That information was imparted to the several medical groups by our field staff handling enrollment. It was in the operation of the field staff that this matter had just come up the other day. As a result, we understand that the advice of Blue Cross has been transmitted back to committee.

Now, I speak with no bias and no reflection on the judgment of the medical profession as to what it wants nor on the merits of the particular program insofar as the security is concerned in relation to the financial stability of the insurance company. We have not seen the program and we do not know what insurance company is going to underwrite it. But we do know from this brief explanation that the result will be destructive in terms of the overall economy of the program we are selling. Blue Cross is anxious over the years and with coordination with the Medical-Surgical Plan to maintain constantly the best of relationship with the profession.

The medical profession may not want a major medical program which includes physicians' fees. This is evidenced by the fact that when there was effort made by Medical-Surgical Plan to make available enrollment under that Plan with the doctor, a number of doctors' groups or societies indicated no economic interest because of the reciprocal arrangement which exists as a matter of tradition over the years in the matter of one doctor treating another. Therefore, there was no financial interest on the part of the doctor collecting for the services rendered a fellow physician. But it does pose the problem aimed directly at the economics of the hospital end.

We have in Blue Cross a reimbursible cost program with our contracting hospitals. Our liability contractually is established *in advance* of the services being rendered and therefore the subscriber is relieved of payment to the hospital to the extent of the area of coverage of that hospital bill. That will not affect the hospitals in that field of payment from us and the hospital will not be in a position to collect this $1200 I mentioned a moment ago because it's already collected from Blue Cross. The amount to the private duty nurse will be the only part, therefore, that the doctor will be paying out of this fund and the rest of the money will be money in pocket.

Major medical insurance gives relief financially to the unfortunately stricken in a catastrophic sense only to the extent of perhaps two or three out of a hundred. The regular major medical pattern superimposed on Blue Cross and Medical-Surgical Plan generally is one that I mentioned that starts where both the basic Plans leave off. That in itself has been destructive to the insurance companies because they have not been able to control the

amount of encouragement that seems to have been developed among such insured wanting everything that they can get their hands on.

I'm reminded, in my closing comment, of one of the insurance company officials who was responsible for conceiving major medical. When I met him on the train coming from Chicago he said he had made the trip to Chicago to see one company where two claims had arisen. One was the president of the company going to a psychiatrist, taking "couch treatments" to the tune of $10,000. And the other one was going to a dentist, getting a new denture at a cost of $1500, a denture to build it up to the tune of $10,000.

Well, you get problems like that. They only come back indirectly but do affect your Medical-Surgical Plan. They do affect Blue Cross, and the overall utilization cost at the top level of major medical actually does have an effect at the bottom level in terms of duration of stay.

Dr. Schaaf: Thank you very much, Mr. Durgom.

Dr. F. Albert Graeter (Passaic): I should like to reply to Mr. Durgom. Now, as far as the county being covered by Blue Cross, we pay our regular fees and we get the service through our Blue Cross. If we want to buy catastrophic insurance, we're paying premiums on that. And if, as Mr. Durgom said, which can happen, we do make money on it, who is paying for that money that we are going to get? We are paying for it in the fees that we are remitting for that insurance. It could be classed as a type of disability insurance. We should all have that. I don't think Mr. Durgom objects to us buying disability insurance. And with a catastrophic policy, if this is the only kind of a policy you can get and these are the only benefits you can get, if we do make money on it we can cut down on whatever disability insurance we do have. I see no reason why you can't buy another policy and perhaps make money on it. You are paying for it; they are not giving you anything. And I can't see that it's any concern of Blue Cross as long as we pay the premiums that they ask us and as long as we receive whatever benefits they give, have said they would give us. I do not see why they can interfere with us if we care to cover ourselves with a catastrophic type of insurance.

Mr. Durgom: You are correct in that you are paying the premium and expect a return for this added investment. But where Blue Cross is affected is in the utilization.

Let me give you a brief illustration of the point. So long as there is this additional money over and beyond the amount needed to cover the hospital bill, because Blue Cross covered the basic part, there will be the tendency toward increased utilization. Consider private duty nursing which Blue Cross does not cover and which may be elective at a certain stage in this period of hospital confinement. There is no reason for the person *not* remaining in the hospital longer for the extended convalescence, knowing it's not costing anything because where Blue Cross fell off on private duty nursing, the insurance company picked up. We have no objection to coverage of an item that is *not* covered under Blue Cross; but the program is designed to overlap and duplicate the other areas of the hospital services for which Blue Cross has already paid the hospital.

Dr. Leonard Brown (Bergen): I have a major medical policy issued through the American College of Surgeons, possibly the American College of Obstetricians. I don't recall. Am I correct in inferring, that Blue Cross will *not* permit me to carry this because there is an overlapping arrangement with Blue Cross and one of the major medical plans?

Mr. Durgom: At the present time, Doctor, the underwriting practice of Blue Cross is centered around groups. If the group in which you are a member are in this program, then the group would be terminated. Our next step now with this new program lying ahead that we have under advisement will apply also to individuals.

Now, this has a historical background. It is nothing new conceived by Blue Cross in any unilateral sense. There has been over a period of years the traditional feeling that if a person paid two premiums, he was entitled to two payments. However, fire insurance companies stopped it, as you know. You can't get paid twice for the burning down of one house.

On the other hand, during the period of the last several years of the overlapping payments, many individuals, perhaps such as you, have some form of other coverage for indemnification purposes. We will need to face that because we are in a very vulnerable spot, not only Blue Cross, but Medical-Surgical Plan. When we hear the battle cry among the public of increasing rates from time to time, then the question arises: What are you doing about utilization? This is the source of the whole problem. Major medical is one of the causes.

Dr. Elmer L. Grimes (Camden): How much of a factor is this statistically? I can see where theoretically it is, but what are the actual statistics?

Mr. Durgom: Five years ago Blue Cross

was exposed to a senate inquiry prompted by one of the leading labor groups. It took as its issue against the Plan the fact that the Plan was terminating groups from among its membership for buying dual coverage. The inquiry gave Blue Cross the opportunity to present the facts. The Department of Banking and Insurance sent an examiner to examine all of the utilization. The situation was just exactly as the position we presented and the Insurance Department recognized that was a dangerous underwriting practice and we have been upheld in our action.

Neither Medical-Surgical Plan nor Blue Cross are on "experience ratings" now; therefore, all rates are like rates among all groups regardless of the utilization claim cost among the groups. A group with a 150 claim cost (in other words, getting $1.50 in claims for every dollar of premium paid) pays no more than the premium that was charged. That's the "community rating" concept. Other groups that have a low utilization, don't have any double coverage and for other reasons happen to have a favorable claim experience are being over-charged under the "community rating" when they only use, say, 70 cents of the premium dollar for claims. We found that in double coverage, the utilization cost was the highest among them because of this incentive which is human nature, perhaps, and not to be critical of any unlawful act or anything. There was a tendency to over-use the basic coverage.

Dr. Theodore K. Graham (Passaic): Since you don't think that the major medical taken from these other companies is compatible with yours, why don't you have a major medical that we *can* use? Blue Cross is not enough to cover a man if his family has a major illness.

Mr. Durgom: Doctor, you are a welcome ally. I'm only a layman. Medical-Surgical Plan determines its own policies, and properly so. And Blue Cross has its management decisions to make. Blue Cross is in the peculiar but stimulating position of being a sales agency for Medical-Surgical Plan, which is the reason for this representation of Blue Cross here today. It is up to Blue Cross to make studies and make recommendations or at least report observations as to the situation.

Blue Cross is "major medical" for 120 days in hospital because it's full coverage, in effect, outside of this business of private duty nursing and private room not being in full covered by Blue Cross.

Blue Cross has under advisement an "extended benefit program" which would call for convalescent care out of hospital in nursing institutions licensed for that purpose and perhaps an extension to home care. We are now in the stage of a pilot study. I'm speaking now of Blue Cross.

We can protect this invasion of what we consider an unsound underwriting under the insurance company's "major medical" because we will have contracts at service levels with such convalescent institutions, make contractual arrangements with visiting nurses and thus have a control price on the outgo of the premium. Commercial insurance companies do not have that kind of control.

I speak only for Blue Cross. From the Medical-Surgical Plan point of view, that's another matter. But I must say this major medical-surgical along with Blue Cross have perhaps the most comprehensive basic coverages in the country, evidenced by the rapid enrollment growth of the two Plans. But where the Medical-Surgical went on an income level to $5000 single and $7500 for family, it led the country on that. So it has been progressive. But in some areas it has a tendency to go beyond that income level. I cannot dwell on that point without getting out of my realm, but it's one of the matters that some day will be more and more requested.

Dr. Graeter: Practically all doctors have health and disability insurance and when we are sick for any reason we collect on them. Many doctors have varying amounts, some from a thousand to two thousand dollars a month perhaps. Are you against this type of insurance, too, because it gives us money and therefore may lead to abuse?

Mr. Durgom: No, because that replaces income lost. What I don't like is a program where there is *duplication of payment* for the services rendered. If this "major medical" program that's under consideration would start where Blue Cross stops, there would be no problem. But this is one that's unusual in its type. It's not the general run of the kind of major medical. This one takes all payments, bills to hospital over $500, notwithstanding that Blue Cross went over the brink beyond the $500. That's the only complaint. Any duplication of coverage whereby the one dispensing the service—the hospital—can collect once, not twice, means money in pocket. This is contrary to the concept of sound underwriting of health insurance.

Dr. Robert E. Jennings (Essex): Life insurance pays on all the policies you have when you die. It would seem to me that if you have Blue Cross coverage, then when you select a policy such as the Academy of Pedia-

trics has with Lumbermen's Mutual, there should be some proviso in there if you have Blue Cross then your premium rate on your major medical would be less. We are not anxious to get remuneration for being sick; but if you are going to provide for this catastrophic illness, and this is the only way you can do it, we should at least have something that will be put out as a Blue Cross rider that would take up this type of thing. But if you are not interested in doing it because you are afraid of what the risk is going to be until the experience is built up, I don't think we should be penalized. Certainly any group that is so covered is fortunate and I would presume that out of the doctors in the State, those that belong to any specialty group, already have this coverage from Lumbermen's.

Mr. Durgom: I cannot follow your reference to life insurance in terms of a series of policies being analogous to the "major medical." When a person buys a series of life insurance policies they are trying to buy as much as they can economically afford to buy in premiums to replace the loss of life. And I don't suppose there is any limit in the value of one's life and once it's gone, therefore, there is not an overlapping of payment. Whereas, in the instance of the major medical dealing with hospitals we are talking about a hospital bill of a specific sum of money and for which a multiple of policies begins to duplicate the payments in excess of the amount of that bill in total, and that is where the economics goes off in the wrong direction.

Dr. Henry J. Mineur (Union): May we progress to another related "dual coverage" question in relationship to the withdrawal of the diagnostic rider from Medical-Surgical? My specific question is: Is there not to be a delineation between what is the practice of medicine and what is hospital corporate practice? Is the reason this was withdrawn because the hospitals want to get into the practice of medicine and therefore we, as physicians, are saying "no," we won't provide the coverage because of that?

Dr. Schaaf: I will ask Dr. Borsher to answer that question. I can answer it, but I'd rather let somebody else talk once in a while.

Dr. Borsher: I just wish to bring to your attention that the President of the Medical Society, Dr. Bowers, specifically requested that at this open discussion on the Medical-Surgical Plan there be no discussion on the diagnostic riders because the subject is going to be presented in full at the Reference Committee and he specifically requested that no discussion be held of that matter so that there be no undue influence.

Dr. Graham: One of your field men said that Blue Cross, Blue Shield perhaps knew of companies where "major medical" could be tied in. I'l like to have some information on that.

Mr. Durgom: We never name companies and we never recommend a particular program. We can tell you in an overall sense so that you won't feel that there is any escaping from the problem.

The typical major medical now sold and which does not affect Blue Cross basic coverage is the kind that starts to pay for an extended illness where Blue Cross drops off in its liability. In other words, if the person had Blue Cross, that kind of major medical reads like this: that you will be covered after Blue Cross has completed its liability, Number One. Number Two, after a corridor of $100 borne by you beyond the amount of Blue Cross liability towards the bill, then the third step is the company will pay 80 per cent of the balance and you pay 20 per cent. In that instance, you see, there is no duplication of payment.

Dr. Schaaf: Gentlemen, the time is getting short. I will allow a few more minutes for this discussion, but I would like to know whether there are comments or criticisms or suggestions on the subject of the Medical-Surgical Plan itself. I think this is very instructive and interesting, but if we go without hearing any criticism we'll think we are much better than we actually are.

Dr. A. Guy Campo (Gloucester): I have had a number of requests now for coverage and asked whether Blue Cross would cover on a policy in which the husband is disabled; he doesn't want to be covered; or if the wife is disabled and she does not want to be covered, but for coverage of the healthy wife or the healthy husband plus the children.

Mr. Durgom: We have an established underwriting policy that where there is a disabled member of the family we waive the insistence of that person being covered and we enroll the rest of the family at a premium adjusted to the kind of status of that family. In other words, if it was a husband and wife and the husband is incapacitated, we will enroll the wife and children under a single contract. If there is a wife and husband and children and the husband is incapacitated, we will enroll the wife and children at the lower rate of a sole parent with children.

Dr. Jennings: I think it's Item 26 in the new standards concerning transfusions and as-

pirations and it says, to my way of reading it, that if you carry out the number—usually two transfusions—that is allowed by the Plan, that if you do any more transfusions on that child you do them without being able to recover from the Plan or from the parent. That is very inconsistent with the rest of the Plan's program. In other words, you allow coverage for 21 days. It doesn't say if the patient is sick enough to stay in 30 days that you can't charge the patient for the additional services rendered. I'd like to see what the justification is for it. I doubt that it is actually legal, if it would stand up.

Dr. Alfano: That policy conforms with our general overall policy for all surgery. The Plan has a minimum payment of $350 for all surgical procedures that may be done during a single operative period or a maximum payment of $450 for multiple surgical procedures performed during a single hospital admission, if less than 90 days. We do have a provision that if the hospitalization is 90 days or more and there are multiple procedures performed during that period of hospitalization, the Plan will pay up to $800. However, in a less than 90-day hospital admission we do have a maximum payment of $450 and regardless of the number of surgical procedures performed during that period, which if computed on the basis of the schedule would have exceeded the $450, we still pay the maximum of $450.

Dr. Jenning: And the surgeon can charge if he does other work?

Dr. Alfano: Not a participating surgeon, if the income of the subscriber is within the contract limits.

Dr. Schaaf: Some one else have a question? If not, thank you all for coming.

(The meeting was then adjourned at 4:55 p.m.)

County Society Reports • • •

Bergen

The regular meeting of the *Bergen County Medical Society* held Tuesday, September 13 at Bergen Pines Hospital, Paramus, was called to order by George O. Rowohlt, M.D., President. There were approximately 75 members and 40 guests present.

Introduction of new members was followed by announcements.

The Chair noted that members of the Auxiliary and other wives of members were in attendance and welcomed them to the meeting.

The Secretary read a resolution concerning the death of Dr. Thomas R. Carroll.

President Rowohlt presented Dr. John L. Olpp, Chairman of the Legislative Committee, to introduce the speakers and act as moderator during the question and answer period following the presentations. Dr. Olpp then introduced the Honorable Frank C. Osmers, Jr. of Tenafly, Republican Congressman from the Ninth Congressional District, and his opponent, Mr. Vincent T. McKenna of Cliffside Park, Democratic candidate for Congressman from this district. Both gentlemen brifly presented their own personal views as well as those of their respective parties on pending federal legislation. They emphasized the legislation which is of particular interest to the medical profession. It was in this field that differing basic concepts of the need for legislation were most clearly drawn. This was the first actual meeting of the two speaker-candidates.

At the close of their remarks, both the speakers answered written questions which were collected from the members and their wives.

CHARLES P. CAMPBELL, M.D.

Reporter

Announcements • • •

Diabetes Symposium

All day Friday, November 11, has been set aside for a colloquium on diabetes at the Hotel New Yorker, Eighth Avenue at 34th Street, New York. Sponsored by the N. Y. Diabetes Association, the program will cover genetic and clinical aspects of diabetes and will be offered by a faculty of well-known authorities. For details, write to N. Y. Diabetes Association, 104 East 40 Street, New York 16. While there is no fee, admission will be limited to those holding tickets furnished in advance by this Association.

Medical Aspects of Sports

Just before the AMA clinical meeting next month, a conference will be held on the medical aspects of sports. Lectures and panel discussions are scheduled to cover such topics as medical care of the boxer, nutrition of the athlete, emotional factors in athletics and so on. An illustrated review of the 1960 Olympic Games is also on this program. The session will be at the Statler in Washington, D. C., on November 27, 1960. For details, write to Dr. Frederick Hein, Department of Health Education, A.M.A., 535 North Dearborn Street, Chicago 10.

Radiology Society for GPs

Applications for charter membership in the American Society of Diagnostic Radiology are now being received. Membership is open to general practitioners and internists who do or may desire to do some types of diagnostic radiology in their offices.

For further information write to Louis Shattuck Baer, M.D., 411 Primrose Road, Burlingame, Calif.

Cancer Seminar in New Brunswick

November 20, 1960 is the date for an all-day colloquium of the New Jersey Division of the American Cancer Society, to be held at Rutgers University in New Brunswick. The American Academy of General Practice is co-sponsoring this and approves it for 5 credit hours. All aspects of diagnosis and care of cancer will be discussed.

For further details write to New Jersey Division, American Cancer Society, 623 Central Ave., Newark 7, N. J.

Jersey City Intern Alumni

The Alumni Association of the Jersey City Medical Center will hold its annual banquet on November 19, at the Hotel Plaza in Jersey City.

Red Cross Provides Gamma Globulin

Gamma globulin is provided to physicians for the prevention and modification of measles and hepatitis, through the New Jersey State Department of Health and the American Red Cross.

Dr. S. B. Hays, Director of the Blood Program of the American Red Cross, has advised our Health Department that local stories often ignore the role of the American Red Cross in providing the gamma globulin. The American Red Cross feels that if its role is emphasized, this will stimulate recruitment of blood donors to the Red Cross Blood Program and thus prove beneficial to all of us—especially to patients. Each physician is asked to highlight the contribution of the American Red Cross in providing gamma globulin.

Book Reviews • • •

The Teen Age Years: A Medical Guide for Young People and Their Parents. Arthur Roth, M.D. Garden City, N. Y., 1960. Doubleday. Pp. 288. ($3.95)

Ephebiatrics: medicine for adolescents—is our newest specialty. As Dr. Roth says, the teen-ager is a "medically displaced person"—not quite fitting into adult medicine, too old for the pediatrician. Dr. Roth operates a teen-age clinic, and out of that has come this book dealing with ephebiatric problems from personal grooming to "growing pains." There are chapters on sexual problems, skin disorders, bellyaches, weight control, human plumbing (that's the chapter on the urinary apparatus), eyes, ears, sprains, teeth and mental habits.

The book is directed primarily at the teen-agers themselves, but can be read with profit by their parents and prescribed with assurance by their doctors. The author is the parent of four daughters, so his writing is not entirely theoretical.

VICTOR HUBERMAN, M.D.

Drugs of Choice. Edited by Walter Modell, M.D. With 47 contributors. St. Louis, 1960. Mosby. Pp. 958. Ed. 2. ($13.50)

Somebody has to help the doctor through the jungle of new drugs. The flood of literature expensively provided by pharmaceutical manufacturers threatens to overwhelm us, and several efforts have been made to furnish us with keys to drug therapy. This is the second (and 1960-1) edition of a book that first appeared in 1958 and includes new chapters on local antiseptics, drugs for eye, ear, nose and throat use, and the choice of sedatives and tranquilizers. The general plan is for each chapter to take up "Choice of Drugs for . . ." indicating the area involved, as dermatologic disorders, obstetrics, intestinal parasites and so on.

This has all the merits and defects of any anthology. We get a well-rounded point of view from many different authorities; from some writers a dogmatism which allows of too little flexibility; or conversely a confusing spectrum of drugs with no guidance in selection. Too many chapters are opened by empty generalizations that could well be omitted. Indeed, word wastage is annoyingly obvious through much of the book, though an occasional author does write laconically. There is also some confusion about the use of generic and trade names. The editor has, apparently, permitted each author to follow his personal whim with respect to trade names. Adrenalin appears on only two pages, whereas epinephrine has ten listings in the index. In one chapter we read: ". . . either Dexedrine or amphetamine . . ." If the author wants trade names, why not: Dexedrine or Benzadrine? If he prefers generic names, why not: anphetamine or dextro-amphetamine. And where was the editor all this time? It was, presumably, his job to pick up just such inconsistencies. Throughout the volume there is this crying need for more vigorous editing.

But these are trivial faults. Taken as a whole, here is a volume that will soon earn its keep on any practitioner's book shelf: a veritable, compact graduate course in drug therapy.

HENRY A. DAVIDSON, M.D.

The Cigarette Habit: A Scientific Cure. Arthur King. New York, 1960. Doubleday. Pp. 96. ($2.00)

Mr. King has written in literate and simple language, a small book that may go far towards solving problems met by cigarette smokers who earnestly wish to cease smoking and are unable to do so.

Mr. King's primary field of research is alcoholism. Nearly all of the alcoholics are heavy smokers. As alcoholics, they had recovered, but most found themselves unable to quit smoking. This led logically to an examination of the thesis that smoking might be an addiction.

Mr. King concludes that at least a segment of the smoking population might fall in this category. Cessation of smoking caused symptoms much like the "withdrawal syndrome" of the drug addict. Smokers of this type who were finally successful in their attempts to stop smoking described extreme discomfort for twenty-one days. In drug addiction, it takes twenty-one days to "get the patient off the hook."

Mr. King, a heavy smoker for twenty-five years, decided to make himself the subject of an experiment which would culminate in the successful ces-

sation of smoking without serious physical and psychologic debility. This project is the subject of this book. Smokers are divided into four classes; light, medium, heavy and addicts. The difference between smoking and addiction is qualitative rather than quantitative. A person's category is determined by answering several simple questions included in the text. Any person who is earnest in his desire to quit may follow the simple regimen prescribed by Mr. King and achieve success. In several hundred persons who have tried this system, the author reports 97 per cent success. All of these were "cured" without the usual symptoms of anxiety and irritability which characterize the unassisted person who is attempting to quit. None of these gained weight during or after the "cure."

It seems to me that this small volume would be a valuable addition to the library of professional and lay persons alike. It offers a scientific approach to an ever growing problem, in language we may classify as the American idiom.

JACOB SCHMUKLER, M.D.

New and Nonofficial Drugs, 1960. Council on Drugs of the American Medical Association. Philadelphia, 1959. Lippincott. Pp. 768. ($3.35)

The ever-welcome current edition of NND is now available. The book includes brief monographs on all important drugs developed since the last edition, and in some cases includes a discussion of older drugs where the background information is useful in understanding the newer ones.

The chapters are arranged in terms of use, as, for example, immunologic agents, central nervous system depressants, and the like. Also included are conversion tables and a list of official and regulatory agencies, as well as some practical discussion of the basic principles for the use of each category of drugs.

At the modest bargain price of $3.35, this 768-page volume is a real bargain to any clinician.

ULYSSES M. FRANK, M.D.

Essentials of Healthier Living. J. J. Schifferes, Ph.D. New York, 1960. John Wiley & Sons. Pp. 335. ($5.50)

Most physicians will react swiftly and unfavorably to the idea that a book like this should be written by a layman. In his foreword, however, Howard Craig M.D., points out that physicians are seldom schooled in communication, and that health education is a problem for skilled teachers rather than skilled clinicians. This is a college text in personal and community health. At times, the doctor may find it sketchy to the point of being misleading. "Syphilis at all stages is effectively treated and usually cured with penicillin and other antibiotics. The treatment period is short." Statements like this, for instance, may be challenged as not sound teaching to college students.

The book includes such topics as statistics, detecting health frauds, marriage counselling, "secrets of the unconscious mind," health insurance, accident prevention, atomic energy as a health hazard, how babies are born, food fads and so on. It is fluently written, interestingly illustrated, and carefully conventional in its philosophy. It also includes many review questions and bibliographic references as helps to teachers. It is a good college text and will be useful to the clinician who wants a reference work in connection with lectures to the laity.

ABRAHAM LEFF, M.D.

Medieval and Renaissance Medicine. Benjamin Lee Gordon, M.D. New York, 1960. The Philosophical Library. Pp. 849 with 68 illustrations. ($10.00)

New Jersey's distinguished historian, Benjamin Lee Gordon, has written a book that fills the gap between Roman-Greek classical medicine and medicine of the modern period. This fat volume reviews Arabic and Byzantine contributions to medicine and surveys medieval medicine country by country. Vignettes of the major figures in renaissance medicine add to the interest of the book. All in all, it is a scholarly work and a major contribution to medical history.

HENRY A. DAVIDSON, M.D.

Significant Trends in Medical Research. Edited by G. E. W. Wolstenholme, M.D. Boston, 1960. Little, Brown. Pp. 356. ($9.50)

In 1959, the Ciba Foundation sponsored a symposium on medical research. This book is a compilation of the papers read there. Topics include such items as molecular biology, virus multiplication, genetics, hormone physiology, malignant transformation and "factors influencing the substance and dimensions of medical research." Each chapter is enriched by a verbatim transcript of the give and take of free discussion. The book is pitched at a sophisticated level and, as might be expected, the orientation is to the research physician rather than to the clinician. Hope of medical progress rests largely on advancing the frontiers of research, so that a stimulating text like this will be welcomed by physicians who see the unique role of research in modern medicine.

HERBERT BOEHM, M.D.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

OCTOBER, 1960 • VOL. XXXIII, NO. 8

SOME PRACTICAL ASPECTS OF THE SMOKING-CANCER PROBLEM

The most effective way to alleviate the smoking-cancer problem would be to stop smoking or reduce it to a minimum. Practical measures for reducing the smoke condensate per cigarette are: the use of effective filters, less tobacco per cigarette, tobacco selection and highly porous cigarette paper.

The majority of those who have investigated the epidemiology of lung cancer are in agreement that smoking, particularly of cigarettes, represents one of the causes of cancer of the lung. Several health authorities have publicly supported this view. These include the United States Surgeon General, Leroy Burney, the Director of the National Cancer Institute, John Heller, the American Cancer Society, the Health Commissioner of the State of New York, Herman Hilleboe, and the public-health services of Great Britain and the Netherlands. It is no longer an argument whether smoking affects the development of lung cancer, but rather a question of how the risk of the smoker can be avoided or reduced. The present report is designed to provide some practical answers to this question.

PREVIOUS DATA

It is an accepted principle in carcinogenesis that the greater the exposure to a carcinogen, the greater the risk of cancer. This has also been established for tobacco smoke. Retrospective as well as prospective studies have shown that the risk of lung cancer rises with the number of cigarettes smoked. The Hammond and Horn report in 1958 showed that the non-smoker's incidence of lung cancer is 3.4 per 100,000 per year, and that of a person smoking half to one package a day is 59.3; those smoking between one and two packages have a risk of 143.9; and those smoking more than two packages 217.3. The importance of smoke condensate yield has recently been demonstrated again in butt-length studies. One study has shown that the average butt length of the British smoker is 18 millimeters as compared to 30 millimeters for the American smoker. This difference may account for the higher rate of lung cancer in England.

The amount of smoke condensate that comes into contact with the lung also depends upon the degree to which the smoker inhales. A majority of the published studies indicate that patients with lung cancer tend to inhale more than the control population.

The available studies indicate that a reduction in the yield of smoke condensate of a cigarette and a reduction in the amount that comes in contact with the lung will be followed by a reduction of the risk of lung cancer. The purpose of the present investigation is to determine how these ends can best be achieved and what progress has already been made in this field.

METHODS

We determined the amount of smoke condensate of the ten leading American cigarette brands. The results appear in the table. In a special study

Ernest L. Wynder, M.D. and Dietrich Hoffmann, Ph.D., *New England Journal of Medicine, March 17, 1960.*

we changed the frequency of the puff to two and three times per minute and found that such a change increases the yield of smoke condensate. In another experiment we compared the quantity of smoke condensate collected from the first 30 millimeters of an 85 millimeter cigarette to quantity from the second 30 millimeters of such a cigarette. The second half of the cigarette contained 43±2.2 per cent more smoke condensate than the first half.

We also studied the ultraviolet fluorescence of inhaled and noninhaled cigarette smoke to determine how much of the fluorescent material is absorbed upon inhalation. These studies show that long term smokers absorb 80 to 95 per cent of the condensate upon deep inhalation.

Amount of Smoke Condensate Contained in the Leading Brands of American Cigarettes

Brand	National Position by Sales, 1959	Type	Size mm.	Smoke Condensate per Cigarette mg.	Nicotine per Cigarette mg.
Chesterfield	6	Plain	85	39.8±2.0	2.66±0.14
Pall Mall	2	Plain	85	35.1±1.8	2.42±0.12
Camel	1	Plain	70	30.2±1.5	2.04±0.10
Lucky Strike	4	Plain	70	28.6±1.4	1.87±0.10
Salem	7	Filter	85	26.0±1.3	1.86±0.10
Winston	3	Filter	85	23.0±1.2	1.70±0.09
Viceroy	9	Filter	85	21.4±1.1	1.29±0.07
L & M	8	Filter	85	21.3±1.1	1.37±0.07
Marlboro	10	Filter	85	20.3±1.1	1.32±0.07
Kent	5	Filter	85	17.7±0.9	1.04±0.06

To compare the benzo(a)pyrene content of the smoke condensate of the two leading American non-filter and filter cigarettes, chemical determinations of this, the most potent carcinogenic compound so far identified in tobacco-smoke condensate, were made with the use of a method previously reported. The higher the smoke condensate of a given cigarette, the greater the exposure of the smoker to polycyclic hydrocarbons.

DISCUSSION

For some years our group has been concerned with the marked increase in lung cancer and the related role of cigarette smoking. In 1940 the number of deaths from lung cancer in the United States was 5,353 for males and 1,626 for females. In 1950 14,922 deaths from lung cancer occurred in males and 3,391 such deaths were reported for females; the figures for 1957 are 26,287 and 4,489 respectively. The most effective way to alleviate the problem would be to stop smoking or at least to keep it to a minimum. However, it seems difficult to educate the public effectively in this respect.

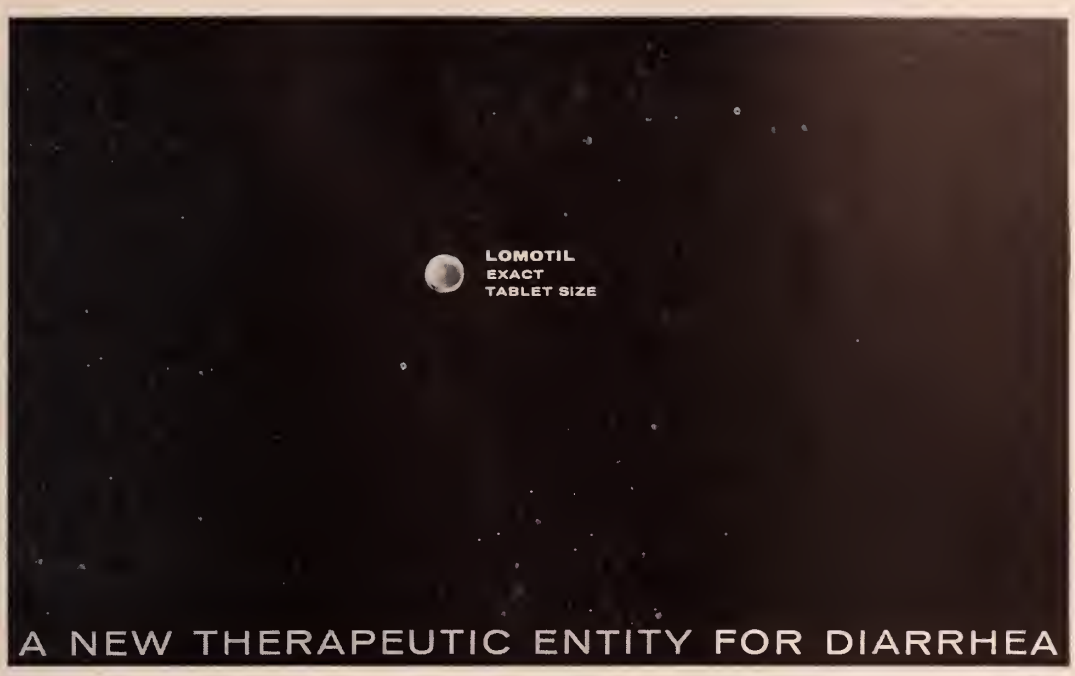
The following measures that should lead toward reducing the risk of cancer of the respiratory tract among smokers are suggested: moderation of smoking for those who cannot give up the habit; use of filter cigarettes with the lowest yield of smoke condensate; avoidance of smoking the cigarette to the butt since there is significantly more condensate from the latter part of the cigarette; and not inhaling deeply since such a practice leads to much greater absorption of smoke condensate by the lungs.

The benzo(a)pyrene content of various cigarette-smoke condensates is similar when judged on a gram-for-gram basis. Per cigarette, however, it increases together with an increase in the amount of smoke condensate. Thus, the user of a cigarette with a high yield of smoke condensate will be exposed to more benzo(a)pyrene than one smoking a cigarette with a lower yield.

Filter cigarettes tend to diminish symptoms, especially that of cough, often found to be associated with smoking.

Further research must be carried out in an attempt to reduce carcinogens and co-carcinogens from tobacco-smoke condensate.

NEW JERSEY TRUDEAU SOCIETY
is the medical section of
NEW JERSEY TUBERCULOSIS AND HEALTH ASSOCIATION
15 EAST KINNEY STREET, NEWARK 2, NEW JERSEY



A NEW THERAPEUTIC ENTITY FOR DIARRHEA

LOMOTIL®

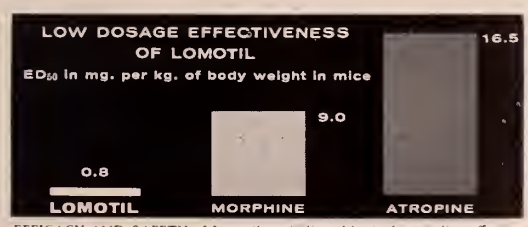
SELECTIVELY LOWERS PROPULSIVE MOTILITY

LOMOTIL represents a major advance over the opium derivatives in controlling the propulsive hypermotility occurring in diarrhea.

Precise quantitative pharmacologic studies demonstrate that Lomotil controls intestinal propulsion in approximately 1/11 the dosage of morphine and 1/20 the dosage of atropine and that therapeutic doses of Lomotil produce few or none of the diffuse untoward effects of these agents.

Clinical experience in 1,314 patients amply supports these findings. Even in such a severe test of antidiarrheal effectiveness as the colonic hyperactivity in patients with colectomy, Lomotil is effective in significantly slowing the fecal stream.

Whenever a paregoric-like action is indicated, Lomotil now offers positive antidiarrheal control . . . with safety and greater convenience. In addition, as a nonrefillable prescription product, Lomotil offers the physician full control of his patients' medication.



EFFICACY AND SAFETY of Lomotil are indicated by its low median effective dose. As measured by inhibition of charcoal propulsion in mice, Lomotil was effective in about 1/11 the dosage of morphine hydrochloride and in about 1/20 the dosage of atropine sulfate.

PRECAUTION: While it is necessary to classify Lomotil as a narcotic, no instance of addiction has been encountered in patients taking therapeutic doses. The abuse liability of Lomotil is comparable with that of codeine. Patients have taken therapeutic doses of Lomotil daily for as long as 300 days without showing withdrawal symptoms, even when challenged with nalorphine.

Recommended dosages should not be exceeded.

DOSAGE: The recommended initial dosage for adults is two tablets (5 mg.) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is controlled. Maintenance dosage may be as low as two tablets daily. Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is supplied as unscored, uncoated white tablets of 2.5 mg., each containing 0.025 mg. (1/2400 gr.) of atropine sulfate to discourage deliberate overdosage.

Subject to Federal Narcotic Law.

Descriptive literature and directions for use available in Physicians' New Product Brochure No. 81 from

G. D. SEARLE & CO.
P.O. Box 5110, Chicago 80, Illinois
Research in the Service of Medicine

WHO
WHAT
WHEN
WHERE
WHY

And now **WPAT**

Last spring, leading New Jersey newspapers told the story of Blue Shield through a series of advertisements headlined, "Who", "What", "When", "Where", "Why".

This fall, through radio station WPAT—930 on both A.M. and F.M. Dial—Blue Shield will tell 2,700,000 people *every week* how Blue Shield and its 6,000 participating physicians care for them.

These one minute messages are aimed at giving the people of New Jersey a clearer understanding and deeper appreciation of the Medical-Surgical Plan of New Jersey . . . and the physicians who make it possible.

Listen to these messages on WPAT and let us know what you think of them.

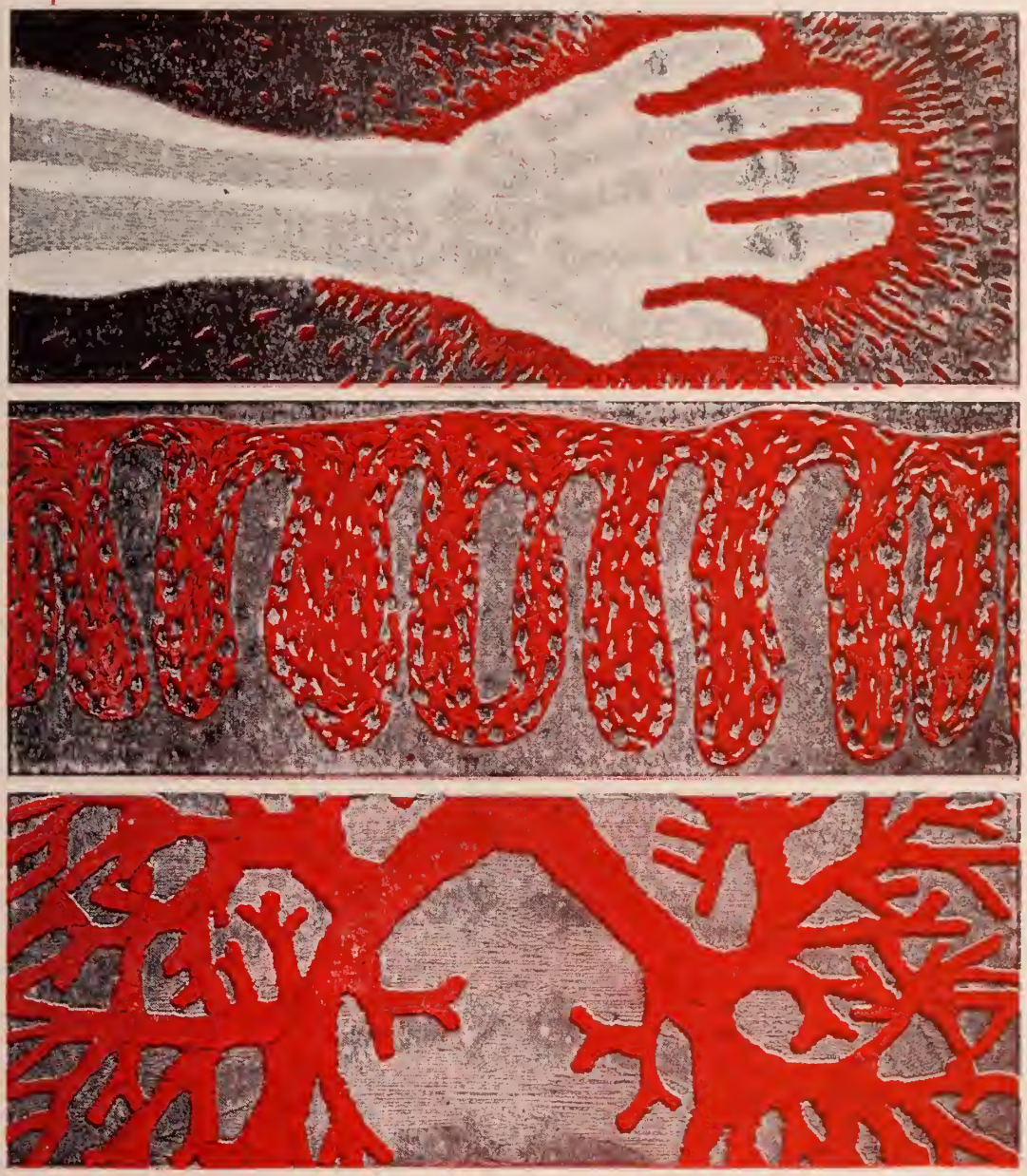
MONDAYS—FRIDAYS
8:30 A.M. on "The Morning Show"
6:00 P.M. on "Limelight" (5 P.M. after October 3)

SATURDAYS
12 noon—2 P.M. on "Gaslight Previews",
(two spots) 5-6 P.M. on "Limelight"

SUNDAYS
1-2 P.M. on "Gaslight Previews"
4-5 P.M. on "Limelight"

BLUE SHIELD
Medical-Surgical Plan of New Jersey
Camden NEWARK Trenton

a promise fulfilled



All corticosteroids provide symptomatic control in rheumatoid arthritis, inflammatory dermatoses, and bronchial asthma. They *differ* in the frequency and severity of side effects. Introduced in 1958, ARISTOCORT Triamcinolone bore the promise of high efficacy and relative safety. Physicians today recognize that the promise has been fulfilled . . . as evidenced by the high rate of refilled ARISTOCORT prescriptions.

Aristocort® Triamcinolone LEDERLE

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, N.Y.

STEREO WEBCOR

WEBCOR REGENT CORONET STEREO HI-FI TAPE RECORDER

$329.95

- Will record and play back both stereo and monaural tapes
- Provides 2-channel and 4-channel stereo playback
- Dual-channel 16-watt amplifier
- Self-contained Stereo system with 2 Hi-Fi Speakers
- 2 directional microphones
- In ebony with silver trim

Model 2007

Available at all

DEPT. STORES AND BETTER MUSIC, RECORD, CAMERA AND APPLIANCE DEALERS

Write for catalog to Exclusive N. J. Wholesale Distributors

ALL-STATE DISTRIBUTORS,

INCORPORATED

457 CHANCELLOR AVENUE - WAverly 3-4900 - NEWARK, N. J.

when pressure is a problem

Reduce pressure through bradycardic, tranquillizing action....

'Rauwistan'

the MRT-standardized Rauwolfia

BECAUSE its unique chemical and biological standardization assures uniformity and consistency of effect time after time with high activity and minimal incidence of side effects.

SUPPLIED: Tablets of 50 and 100 mg., in bottles of 100.

DOSAGE: 100 to 300 mg. daily, in divided doses.

Reduce pressure through bradycardic, tranquillizing plus direct hypotensive action....

'Verwolfia'

the MRT-standardized Rauwolfia-Veratrum

BECAUSE it adds to Rauwistan the specific hypotensive effect of uniquely standardized Veratrum and assures uniformity and consistency of effect time after time with high activity and minimal incidence of side effects.

SUPPLIED: 50 mg. of Rauwolfia serpentina and of Veratrum viride (standardized whole root) in each tablet; in bottles of 50 and 100.

DOSAGE: 1 to 3 tablets daily for the first 2 or 3 days; then 1 or 2 tablets daily, as required.

MRT *M.R. Thompson, Inc.* Cranford, N. J.

Use of pHisoHex for washing the skin augments any other therapy for acne — brings better results. Now, pHisoAc Cream, a new acne remedy for topical application, suppresses and masks lesions — dries, peels and degerms the skin. Together, pHisoHex and pHisoAc provide basic complementary topical therapy for acne.

pHisoHex, antibacterial detergent with 3 per cent hexachlorophene, removes soil and oil better than soap — provides continuous degerming action when used often. pHisoHex is nonalkaline, nonirritating and hypoallergenic.

When pHisoAc Cream is used with pHisoHex washings, it unplugs follicles, helps prevent development of comedones, pustules and scarring. New pHisoAc Cream is flesh-toned, not greasy. It contains colloidal sulfur 6 per cent, resorcinol 1.5 per cent, and hexachlorophene 0.3 per cent in a specially prepared base. pHisoAc is pleasant to use.

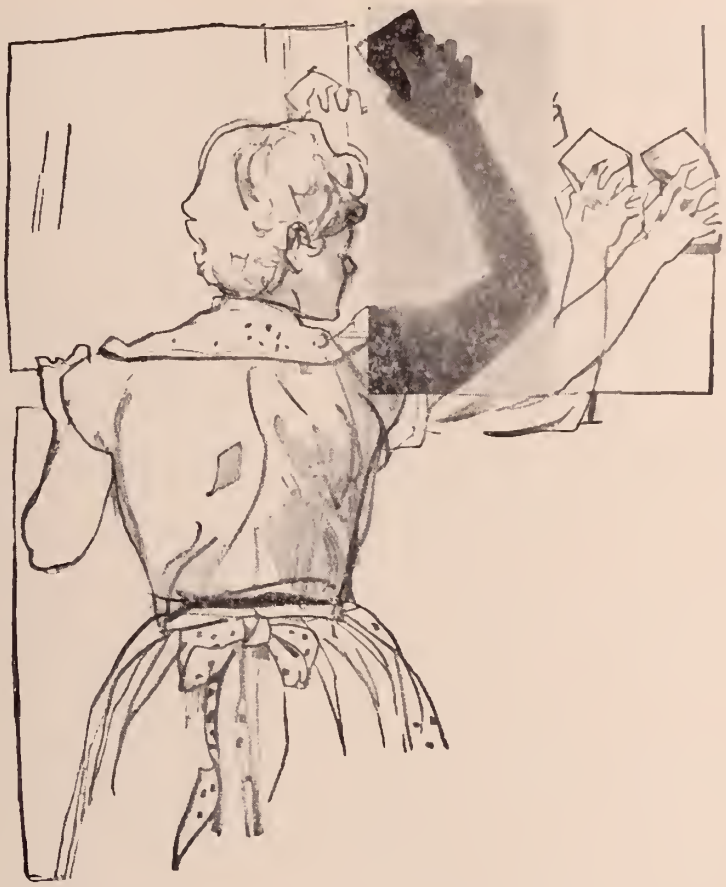
A new "self-help" booklet, **Teen-aged? Have acne? Feel lonely?**, gives important **psychologic first aid** for patients with acne and describes the proper use of pHisoHex and pHisoAc. Ask your Winthrop representative for copies.

pHisoAc is available in 1½ oz. tubes and pHisoHex is available in 5 oz. plastic squeeze bottles and in bottles of 16 oz.

pHisoHex® and pHisoAc for acne

trademark

Winthrop
LABORATORIES
New York 18, N. Y.



To the relief of musculoskeletal pain, new MEDAPRIN* adds restoration of function

Analgesics offer temporary relief of musculoskeletal pain, but they merely *mask* pain rather than getting at its *cause*. New Medaprin, in addition to bringing about prompt subjective improvement, promotes the *restoration of normal function* by suppressing the inflammation that *causes* the pain.

Medaprin, Upjohn's new analgesic-steroid combination, contains aspirin plus Medrol,** the corticosteroid with *the best therapeutic ratio in the steroid field.*† Instead of suffering recurrent discomfort because of the "wearing off" of analgesics, the patient on Medaprin experiences a smooth, *extended* relief and more normal mobility.

Indications: Medaprin is indicated in mild-to-moderate rheumatic and musculoskeletal conditions, including rheumatoid arthritis, deltoid bursitis, low back pain, neuralgia, synovitis, fibromyositis, osteoarthritis, low back sprain, traumatic wrist, sciatica, and "tennis elbow."

Dosage: The recommended dosage is 1 tablet q.i.d. The usual cautions and contraindications of corticotherapy should be observed.

Supplied: In bottles of 100 and 500.

Formula: Each Medaprin tablet contains

- 300 mg. acetylsalicylic acid, for prompt relief of pain
- 1 mg. Medrol, to suppress the causative inflammation
- 200 mg. calcium carbonate, as buffer

*TRADEMARK **TRADEMARK, REG. U.S. PAT. OFF. — METHYLPREDNISOLONE, UPJOHN
†RATIO OF DESIRED EFFECTS TO UNDESIRED EFFECTS

The Upjohn Company, Kalamazoo, Michigan **Upjohn**

REPRESENTATIVE FUNERAL DIRECTORS

OF THE STATE OF NEW JERSEY

Special and Dependable Service Day and Night. Special Attention Given to Hospital Calls, Train and Express Shipments.

PLACE	NAME AND ADDRESS	TELEPHONE
ADELPHIA	C. H. T. Clayton & Son	FReehold 8-0583
ASBURY PARK	Ely Funeral Home, 514 Second Ave.	PRospect 5-0567
ASBURY PARK	Matthews, Francioni & Taylor Funeral Home, 704 7th Ave.	PRospect 5-0021
ATLANTIC CITY	H. M. Gormley Funeral Home, 911 Pacific Ave.	ATlantic City 4-3188
BERGENFIELD	Riewerts Memorial Home, 187 S. Washington Ave.	DUmont 4-0700
BLOOMFIELD	The Howard W. Kopf Funeral Home, 401 Franklin St.	PIlgrim 3-1396
BLOOMFIELD	George Van Tassel's Community Funeral Home	PIlgrim 3-1234
BOONTON	Lewis & Carey Incorporated, 312 W. Main St.	DEerfield 4-0842
CAMDEN	F. T. Walker & E. E. Walker Fun. Home, 743 Chestnut St.	WOodlawn 3-2581
CHATHAM	Wm. A. Bradley Funeral Home, 345 Main St.	MErcury 5-2428
COLLINGSWOOD	Schaffhauser Funeral Home, 983 Haddon Ave.	ULysses 4-5454
CRANBURY	A. S. Cole Son & Co., Main St.	EXport 5-0770
ELIZABETH	Aug. F. Schmidt & Son, 139 Westfield Ave.	ELIzabeth 2-2268
ENGLEWOOD	Greenleaf Funeral Home, Inc., 108 W. Palisade Ave.	ENglewood 3-0416
FREEHOLD	Van Sant Funeral Home, 73 South St.	FReehold 8-0693
HOBOKEN	Failla Memorial Home, 533 Willow Ave.	HOboken 3-0082
JERSEY CITY	Patrick J. Conte Funeral Home, 36 Tuers Ave.	HE 5-6451, DE 3-9259
JERSEY CITY	McLaughlin Funeral Home, 591 Jersey Ave.	OLdfield 3-2266
JERSEY CITY	Donald F. Wood Funeral Residence, 582 Bergen Ave.	DElaware 3-6480
LINDEN	Don McCracken Funeral Home, 2124 St. Georges Ave., E.	ELizabeth 2-3270
LITTLE FALLS	Norman A. Parker Funeral Home, 47 Main St.	CLifford 6-4700
METUCHEN	Runyon Mortuary, 568 Middlesex Ave.	LIberty 8-0149
MOORESTOWN	Harvey H. Brown Funeral Home, 10. W. Main St.	BElmont 5-5555
MORRISTOWN	Raymond A. Lanterman & Son, 126 South St.	JEfferson 9-2880
NEWARK	Barrish Funeral Home, 684 Clinton Ave.	ESsex 3-1551—9179
NEWARK	Beckett's Funeral Home, 120 W. Market St.	MItchell 2-4068
NEWARK	James E. Churchman Service, 132 Clinton Ave.	BIgelow 8-1672
NEWARK	Peoples Burial Co., 84 Broad St.	HUmboldt 2-0707
NEWFOUNDLAND	Stickle Funeral Home, Union Valley Road	OXbow 7-8141
PARAMUS	Vander Plaat Memorial Home, S-113 Fairview Ave.	DIamond 2-3688
PATERSON	R. Charles D. Legg & Sons, 384 Broadway	SHerwood 2-2385
PATERSON	Moore's Home for Funerals, 384 Totowa Ave.	ARmory 8-1500
PATERSON	Scanlan Funeral Homes, 421 Twelfth Ave. at E. 28th St.	SHerwood 2-6433
PATERSON	Vermeulen Memorial Funeral Home, 131 Haledon Ave.	MUlberry 4-3974
POINT PLEASANT	George W. Whateley Funeral Home, 1105 Arnold Ave.	TWinbrook 9-0792
RAHWAY	Lehrer Funeral Home, 275 W. Milton Ave.	FUlton 8-1874
RAMSEY	The Harold Van Emburgh Funeral Home, Inc.	DAvis 7-0030
RIDGEWOOD	C. C. Van Emburgh, Inc., 306 E. Ridgewood Ave.	GIlbert 5-0344
RIVERDALE	George E. Richards, Newark Turnpike	TEmple 5-0164
SOUTH AMBOY	The Gundrum Service, 237 Bordentown Ave.	PArkway 1-0241
SOUTH RIVER	Rezem Funeral Home, 190 Main St.	SOuth RIver 6-1191
SPOTSWOOD	Hulse Funeral Home, 455 Main St.	SOuth River 6-3041
TRENTON	Daniel Brenna Funeral Home, 340 Hamilton Ave.	EXport 3-2857
TRENTON	Ivins & Taylor, Inc., 77 Prospect St.	EXport 4-5186
TRENTON	Poulson & Van Hise, 408 Bellevue Ave.	EXPORT 6-8168
TRENTON	Saul Funeral Homes	JUniper 7-8221 and JUniper 7-0170
WEST ENGLEWOOD	Clifford H. Peinecke Funeral Home, 1312 Teaneck Rd.	TEaneck 7-2332

in common Gram-positive infections due to susceptible organisms

YOU CAN COUNT ON

TAO®

(triacetyloleandomycin)

even in many resistant Staph*

1,928 published cases in the two years since TAO was released for general use show:

94.3% effectiveness in respiratory infections (617 cases including tonsillitis, staphylococcal and streptococcal pharyngitis, bronchitis, infectious asthma, broncho-pneumonia, lobar pneumonia, bronchiectasis, lung abscess, otitis.) **You can count on TAO.**

92% effectiveness in skin and soft tissue infections (900 cases including pyoderma, impetigo, acne, infected skin disorders, wounds, incisions and burns, furunculosis, abscess, cellulitis, chronic ulcer, adenitis.) **You can count on TAO.**

87.1% effectiveness in genitourinary infections (349 cases including urethritis, cystitis, pyelitis, pyelonephritis, orchitis, pelvic inflammation, acute gonococcal urethritis, lymphogranuloma venereum.) **You can count on TAO.**

75.8% effectiveness in diverse infections (62 cases including fever of undetermined origin, peritoneal abscess, osteitis, periarthritis, septic arthritis, staphylococcal enterocolitis, gastroenteritis, carriers of staphylococci.) **You can count on TAO.**

95.6% of 1,928 cases free of side effects—in the remaining 4.4%, reactions were chiefly mild gastrointestinal disturbances which seldom necessitated discontinuance of therapy.

*In 884 of 1,928 cases the causative organisms were mostly staphylococci. The majority of clinical isolates were found to be resistant to at least one of the commonly used antibiotics and many patients had failed to respond to previous therapy with one or more antibiotics. **TAO proved 93.4% effective in these 884 cases.**

Complete bibliography available on request.

DOSAGE: varies according to severity of infection. Usual adult dose—250 to 500 mg. q.i.d. Usual pediatric dose: 3-5 mg./lb. body weight every 6 hours.

NOTE: In some children, when TAO was administered at considerably higher than therapeutic levels for extended periods, transient-jaundice and other indications of liver dysfunction have been noted. A rapid and complete return to normal occurred when TAO was withdrawn.

SUPPLY: TAO CAPSULES—250 mg. and 125 mg., bottles of 60. TAO ORAL SUSPENSION—125 mg. per 5 cc. when reconstituted, palatable cherry flavor, 60 cc. bottles. TAO PEDIATRIC DROPS—100 mg. per cc. when reconstituted, flavorful; special calibrated dropper, 10 cc. bottles. INTRAMUSCULAR or INTRAVENOUS—10 cc. vials, as oleandomycin phosphate.

OTHER TAO FORMULATIONS ALSO AVAILABLE: TAO®-AC (Tao, analgesic, antihistaminic compound) capsules, bottles of 36. TAOMID® (Tao with Triple Sulfas)—tablets, bottles of 60. Oral Suspension—60 cc. bottles.

For nutritional support VITERRA® Vitamins and Minerals

Formulated from Pfizer's line of fine pharmaceutical products.

ROERIG

New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being™

Specialists in Artificial Human Eyes Exclusively

TRUE TO LIFE

MADE TO ORDER in PLASTIC or GLASS in OUR OWN LABORATORY & FITTED INDIVIDUALLY

DOCTORS ARE INVITED TO VISIT

Referred Cases

Carefully Attended

AND

SATISFACTION

GUARANTEED

Plastic or Glass Selections Sent on Memorandum—Eyes Also Fitted from Stock
Implants and Plastic Conformers in Stock.

FRIED & KOHLER, Inc.

665 FIFTH AVENUE
near 53rd Street

NEW YORK CITY, N. Y.
Tel. ELdorado 5-1970

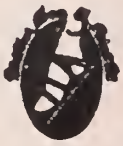
"PRESCRIBE WITH CONFIDENCE"

KATES BROS.

SCIENTIFIC SHOE FITTING

A Shoe and Last for Every Foot

SOLD ON Rx ONLY
CORRECTIVE FOOTWEAR
FOR MEN-WOMEN-CHILDREN



SOLD ON Rx ONLY
OUTFLAIR SHOES
FOR CLUB FEET

177A JEFFERSON AVE.
PASSAIC, N. J.

69 WESTWOOD AVE.
WESTWOOD, N. J.

202 MAIN ST.
HACKENSACK, N. J.

Dennis Brown Splints — in all sizes — carried in stock

"Sometimes, when I have a running nose, I'd like to clear it with TRIAMINIC®— just to check out that systemic absorption business.

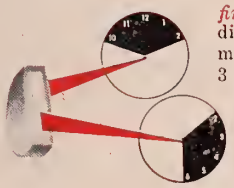
Reaches all nasal and paranasal membranes, huh?"

...and for humans with RUNNING NOSES...

You can't reach the entire nasal and paranasal mucosa by putting medication in a man's nostrils – any more than you could by trying to pour it down an elephant's trunk. TRIAMINIC, by contrast, reaches *all* respiratory membranes *systemically* to provide more effective, longer-lasting relief. And TRIAMINIC avoids topical medication hazards such as ciliary inhibition, rebound congestion, and "nose drop addiction."

Indications: nasal and paranasal congestion, sinusitis, postnasal drip, upper respiratory allergy.

Relief is prompt and prolonged because of this special timed-release action:



first—the outer layer dissolves within minutes to produce 3 to 4 hours of relief

then—the core disintegrates to give 3 to 4 *more* hours of relief

Each Triaminic timed-release Tablet provides:

Phenylpropanolamine HCl	50 mg.
Pheniramine maleate	25 mg.
Pyrilamine maleate	25 mg.

Dosage: 1 tablet in the morning, midafternoon and at bedtime. In postnasal drip, 1 tablet at bedtime is usually sufficient.

Each timed-release Triaminic Juvelet® provides:
½ the formulation of the Triaminic Tablet.
Dosage: 1 Juvelet in the morning, midafternoon and at bedtime.

Each tsp. (5 ml.) of Triaminic Syrup provides:
¼ the formulation of the Triaminic Tablet.
Dosage (to be administered every 3 or 4 hours):
Adults—1 or 2 tsp.; *Children 6 to 12*—1 tsp.;
Children 1 to 6—½ tsp.; *Children under 1*—¼ tsp.

TRIAMINIC® *timed-release tablets, juvelets, and syrup*

STOP *running noses* *and open stuffed noses orally*

SMITH-DORSEY • a division of The Wander Company • Lincoln, Nebraska

FAIR OAKS

SUMMIT, NEW JERSEY

An 80 bed private psychiatric hospital for intensive treatment specializing in the latest therapeutic techniques plus electro-shock and insulin coma therapy. Write

THOMAS P. PROUT, Jr.
Administrator

OSCAR ROZETT, M.D.
Medical Director

P. SINGER, M.D.
E. SOKAL, M.D.
ELIZABETH ROZSA, M.D.
M. E. NEUMAN, M.D.
Associates

Tel. CRestview 7-0143

The Children's Country Home

An accredited 54-bed specialized hospital for handicapped children. Especially equipped for care of cardiac pre- and postoperative cases, cerebral palsy, polio, congenital defects, rheumatoid arthritis, Legg-Perthes' diseases and other orthopedic conditions. Our services include physical therapy and pool treatments, x-ray, occupational and speech therapy. Regular schooling is provided.
The referring physician may continue to prescribe treatment or may transfer responsibility to our staff.

* * *

New Providence Road
Westfield, New Jersey

The Glenwood Sanitarium

LICENSED FOR THE CARE AND TREATMENT OF

NERVOUS AND MENTAL DISORDERS
ALCOHOLISM AND DRUG ADDICTION

Homelike surroundings, good nursing psychiatric treatment, including shock therapy and excellent food.

R. GRANT BARRY, M.D.

2301 NOTTINGHAM WAY TRENTON, N. J.
JUniper 7-1210

PHONE
CH. 2-2330

for well trained highly qualified personnel

MEDICAL
OFFICE ASSISTANTS OR SECRETARIES

Co-Ed (Founded 1936)

N. Y. State Licensed Day-Eve. Courses
Trained by Physicians for Physicians

Eastern

request Free Cat. 7

SCHOOL FOR PHYSICIANS' AIDES
85 Fifth Ave. (16th St.) New York 3, N. Y.
affiliated with CARNEGIE INSTITUTE, INC. *Cleveland, O.*

ATARAX ENCOMPASSES MORE PATIENT NEEDS...LETS YOU CHART A SAFER, MORE EFFECTIVE COURSE TO TRANQUILITY

ATARAX has a wide range of flexibility . . . from mild adult tensions and anxieties to full-blown alcoholic episodes . . . from the behavior disorders of childhood to the emotional problems of old age. Why? Because it gives you maximum adaptability of dosage . . . works quickly and predictably . . . is unsurpassed in safety.

ATARAX offers extra pharmacologic actions especially useful in certain troublesome conditions. It is antihistaminic and mildly antiarrhythmic, does not stimulate gastric secretions. Hence it is well suited to the needs of your allergic, cardiac and ulcer patients.

Have you discovered all the benefits of ATARAX?

Dosage: Adults, one 25 mg. tablet, or one tbsp. Syrup q.i.d. Children, 3-6 years, one 10 mg. tablet or one tsp. Syrup t.i.d.; over 6 years, two 10 mg. tablets or two tsp. Syrup t.i.d.

Supplied: Tiny 10 mg., 25 mg., and 100 mg. tablets, bottles of 100. Syrup, pint bottles. Parenteral Solution: 25 mg./cc. in 10 cc. multiple-dose vials; 50 mg./cc. in 2 cc. ampules. Prescription only.

Complete bibliography available on request.

ATARAX®

(BRAND OF HYDROXYZINE)

PASSPORT TO TRANQUILITY

New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being™

VITERRA® for vitamin-mineral supplementation
• capsules • tastitabs®
• therapeutic capsules

A NATURAL Treatment For Gastro-Intestinal Disorders

An implantation of l. acidophilus bacilli in the digestive tract will frequently restore intestinal flora to a normal, healthy condition. Walker-Gordon Acidophilus (a 2% butterfat product made from Walker-Gordon Certified Milk) abounds in lactobacilli acidophilus... 500 million per ml. Write or phone for professional sample of Acidophilus and complete information.

Guaranteed Free of Penicillin

WALKER-GORDON ACIDOPHILUS

Walker-Gordon Certified Milk Farm, Plainsboro, N.J. SWinburne 9-1234

New York: WAlker 5-7300 ☆ Phila.: LOcust 7-2665

Also Producers of Certified Raw, Pasteurized, Homogenized-Vit. D, Skimmed and Fresh Lo-Sodium Milks.
Available through leading Milk Dealers or write Walker-Gordon

---

Dugan's
"Bakers for the Home"

New - LITE DIET BREAD

(White Bread Baked Without Shortening)
Calories per Slice 42 Calories per Oz. 70

ALSO

SALT-FREE BREAD
GLUTEN AND PROTEIN BREADS
100% WHOLE WHEAT
100% Whole Wheat Crackers

New York New Jersey
Connecticut Pennsylvania

"AT YOUR DOOR OR TO YOUR STORE, IT'S DUGAN'S FOR BETTER BAKED GOODS"

Phone for Delivery

HUmboldt 2-6007 in Newark

(or your local phone book for branch nearest you)

A LOGICAL ADJUNCT TO THE WEIGHT-REDUCING REGIMEN

meprobamate **plus** d-amphetamine... reduces appetite...elevates mood...eases tensions of dieting...**without** overstimulation, insomnia or barbiturate hangover.

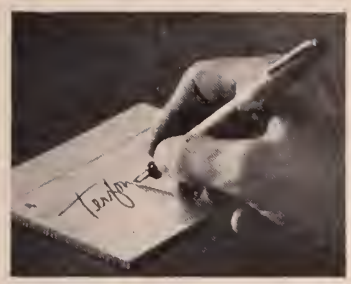
Dosage: One tablet one-half to one hour before each meal.

anorectic-ataractic

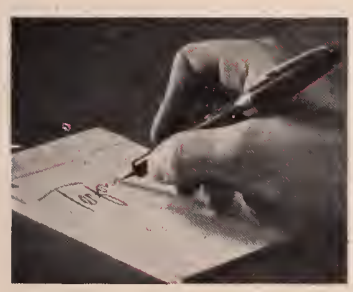
BAMADEX®

meprobamate 400 mg., with d-amphetamine sulfate 5 mg., Tablets

Lederle



more and more physicians are prescribing this triple sulfa



TERFONYL

Squibb Triple Sulfas (Trisulfapyrimidines)

Clinical experience continues to prove that TERFONYL provides many special advantages fundamental to successful antibacterial therapy.

• specificity for a wide range of organisms • superinfection rarely encountered • soluble in urine through entire physiologic pH range • minimal disturbance of intestinal flora • excellent diffusion throughout tissues • readily crosses blood-brain barrier • sustained therapeutic blood levels • extremely low incidence of sensitization

SUPPLY: Tablets, 0.5 gm. • Suspension, raspberry flavored, 0.5 gm. per teaspoonful (5cc.).

SQUIBB *Squibb Quality—the Priceless Ingredient*

"TERFONYL"® IS A SQUIBB TRADEMARK

"Gratifying" relief from

for your patients with
'low back syndrome' and
other musculoskeletal disorders

POTENT muscle relaxation
EFFECTIVE pain relief
SAFE for prolonged use

stiffness and pain

"gratifying" *relief from stiffness and pain in 106-patient controlled study (as reported in J.A.M.A., April 30, 1960)*

"Particularly gratifying was the drug's [SOMA's] ability to relax muscular spasm, relieve pain, and restore normal movement . . . Its prompt action, ability to provide objective and subjective assistance, and freedom from undesirable effects recommend it for use as a muscle relaxant and analgesic drug of great benefit in the conservative management of the 'low back syndrome'."

Kestler, O.: Conservative Management of "Low Back Syndrome", J.A.M.A. 172: 2039 (April 30) 1960.

FASTER IMPROVEMENT—79% complete or marked improvement in 7 days (Kestler)

EASY TO USE—Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

SUPPLIED: 350 mg., white tablets, bottles of 50.
For pediatric use, 250 mg., orange capsules, bottles of 50.

Literature and samples on request.

SOMA®

(CARISOPRODOL, WALLACE)

WALLACE LABORATORIES, CRANBURY, NEW JERSEY

PRESCRIPTION PHARMACISTS

TO THE MEMBERS OF

The Medical Society of New Jersey

PLACE	NAME AND ADDRESS	TELEPHONE
BELLEVILLE	Joralemon Pharmacy, 531 Joralemon St.	PLym'th 9-4535-9858
BERGENFIELD	Horn's Pharmacy, 475 So. Washington Ave.	DUmont 4-1119
BOONTON	Preston Drugs, Del's Village Shopping Center	DEerfield 4-3466
BOUND BROOK	Lloyd's Drug Store, 305 East Main St.	ELliot 6-0150
BUTLER	Pink's Pharmacy, 178 Main St.	BUtler 9-0090, 9-1063
CLIFTON	Fleischner's Pharmacy, 652 Allwood Road	PRescott 7-6689
CLOSTER	Mid Town Pharmacy, 237 Closter Dock Road	CLoster 5-0070
DOVER	Leslie's Drugs, Inc., 9 East Blackwell St.	FOxcroft 6-1405
DUMONT	Lenrow's Pharmacy Inc., 10 W. Madison Ave.	DUmont 4-0842-1500
EDISON TOWNSHIP	Walter's Pharmacy, 1034 Amboy Ave.	LIberty 8-2614
EMERSON	Emerson Pharmacy, 201 Kinderkamack Road	COlfax 2-4999
FLEMINGTON	Green's Pharmacy, 52 Main St.	FLemington 108
FORDS	Fords Pharmacy, Inc., 550 New Brunswick Ave.	HIllcrest 2-4568
GLOUCESTER	King's Pharmacy, Broadway and Market Sts.	GLouc't'r 6-0781-8970
HAWTHORNE	Melcon's Pharmacy, 207 Diamond Bridge Ave.	HAwthorne 7-1546
HIGHLANDS	Highlands Pharmacy, 148 Bay Ave.	HIghlands 3-1058
JERSEY CITY	The Cole Pharmacy, Inc., 710 Grand St.	Delaware 3-9294
JERSEY CITY	J. B. Feinberg Pharmacy, 659 Newark Ave.	OLdfield 3-6376
JERSEY CITY	Honiberg Drug & Surgical Supply Co., 618 Newark Ave.	SWarthmore 8-6700
JERSEY CITY	Lauria's Pharmacy, 768 West Side Ave.	HEnderson 3-1519
JERSEY CITY	S. Taube Inc., 250 Jackson Ave.	HEnd'rs'n 3-2606-0642
JERSEY CITY	Waters Pharmacy, 492 Jackson Ave.	DElaware 3-3043
LAKEWOOD	Alpert's Pharmacy, 224 Clifton Ave., Cor. 3rd St.	FOxcroft 3-3600
LITTLE FALLS	Swisher Pharmacy, Inc., 94 Main St.	CLifford 6-0835
MILLTOWN	Milltown Pharmacy, 21 No. Main St.	MIlltown 8-0081
MILLVILLE	Richard H. Knowles Pharmacy, 600 No. High St.	TAylor 5-0721
MOORESTOWN	Stiles' Pharmacy, 75 East Main St.	BElmont 5-0088
MORRISTOWN	Carrell's Pharmacy (N. E. Corrao, Pharm.) 31 South St.	JEfferson 9-0143
MORRISVILLE, PA.	Pryor's Pharmacy, Bridge St. & Penna. Ave.	CYpress 5-7416
MOUNT HOLLY	Goldy's Pharmacy, Main & Washington Sts.	AMherst 7-2250
MOUNT HOLLY	Mount Holly Pharmacy, 64 Main St.	AMherst 7-0453
NEWARK	Marquier's Pharmacy, Sanford & So. Orange Aves.	ESsex 3-7721
NEWARK	Smith's Pharmacy, 315 So. Orange Ave.	MArket 3-1514

(Continued on following page)

PRESCRIPTION PHARMACISTS

TO THE MEMBERS OF

The Medical Society of New Jersey

(Continued from preceding page)

NEW BRUNSWICK	Bode Drug Co., 120 French St.	KIlmer 5-2676
NEW BRUNSWICK	Hoagland's Drug Store, 365 George St.	KIlmer 5-0048
NEW BRUNSWICK	Rutgers Pharmacy, 429 Livingston Ave.	CHarter 9-6666
NEW BRUNSWICK	Tobin's Drug Store, 335 George St.	CHarter 9-0780
NEW BRUNSWICK	Zajac's Pharmacy, 225 George St.	KIlmer 5-0582
OCEAN CITY	Selvagn's Pharmacy, 862 Asbury Ave.	OCean City 3535
ORANGE	Highland Pharmacy, 536 Freeman St.	ORange 3-1040
ORANGE	Hollywood Pharmacy, 49 Central Ave.	ORange 5-1752
PASSAIC	Wollman Pharmacy, 143 Prospect St.	PRescott 9-0081
PATERSON	Vallario's Pharmacy, 357 Totowa Ave.	ARmory 4-2139
PAULSBORO	Nastase's Pharmacy, 762 Delaware St.	PAulsboro 8-1569
PERTH AMBOY	Jacobs' Drug Store, 434 Amboy Ave.	VAlley 6-3273
PITMAN	Lodge's Pharmacy, 39 So. Broadway	LUther 9-2392
PRINCETON	The Thorne Pharmacy, 168 Nassau St.	WAlnut 4-0077
RAHWAY	Kirstein's Pharmacy, 74 East Cherry St.	RAhway 7-0235
RIDGEFIELD PARK	Lloyd's Prescriptions, 209 Main St.	DIamond 2-8383
RIDGEWOOD	Davis Pharmacy, Inc., 2 Wilsey Square	OLiver 2-2444
ROCKAWAY	Leslie's Drugs, Inc., 36 West Main St.	OAkwood 7-5544
RUMSON	Rumson Pharmacy, W. E. Fogelson	RUmson 1-1234
SOMERDALE	Balaban's Pharmacy, Maiden Lane & White Horse Pike	STerling 3-2956
SOUTH AMBOY	Madura Pharmacy, 115 N. Broadway	PArkway 1-1732
SOUTH ORANGE	Taft's Pharmacy, 2 South Orange Ave.	SOuth Orange 2-0063
TRENTON	Adams & Sickles, State & Prospect Sts.	OWen 5-6396
TRENTON	Delahanty's Pharmacy, State St. at Chambers	EXport 3-4261
TRENTON	Episcopo's Pharmacy, Chambers & Liberty Sts.	EXport 3-3017
TRENTON	Foy's Drug Store, 3024 So. Broad St.	EXport 3-2367
TRENTON	H. S. Hughes, Thatcher Pharmacy, 401 Hudson St.	EXport 2-5616
TRENTON	Kehr's Pharmacy, A. F. Capriotti, R. P., M.P.A.	OWen 5-6807
TRENTON	Lee's Sun Ray Pharmacy, 940 Parkway Ave.	TUxedo 2-3456
UNION	Perkins Union Center Pharmacy	MUrdock 6-0877
UNION CITY	Husni's Pharmacy, 2503 Bergenline Ave.	UNion 5-2577
UNION CITY	Jos. Parentini's Pharmacy, Inc., Charles H. Arnoldi	UNion 7-4806
WEST NEW YORK	The Owl Pharmacy, 6611 Bergenline Ave.	UNion 5-0384
WEST ORANGE	West Orange Pharmacy, 443 Main St.	ORange 4-9824
WRIGHTSTOWN	Bowen's Pharmacy, 152 Fort Dix Road	RAymond 3-2176

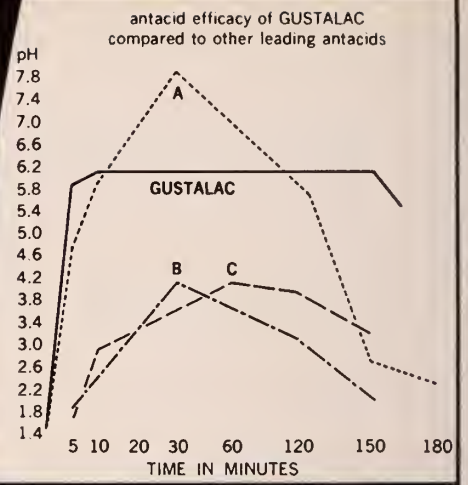
patients welcome the pleasant way

GUSTALAC

TABLETS

give immediate relief from

Gastric and Duodenal ULCERS
HYPERACIDITY
Heartburn of Pregnancy



Each dose eases pain, "burning" and eructation for 2½ hours — two tablets are equal in buffering value to 10 oz. of milk. Does not cause acid rebound, constipation or systemic alkalosis.

PLEASANT TASTING GUSTALAC tablets each provide: the "most potent antacid,"[1] superfine calcium carbonate (300 mg.), buffer-enhanced by a special high protein defatted milk powder (200 mg.).

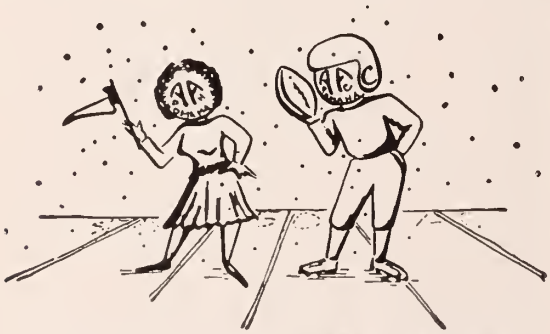
DOSAGE: 2 tablets chewed or swallowed q. 2 to 3 h. PRN and on retiring.

1. Kirstner, J. B.: J.A.M.A. 166:1727, 1958.

Samples and literature on request

GERIATRIC PHARMACEUTICAL CORPORATION
Bellerose, N. Y.

Pioneers in Geriatric Research



Protection against loss of income from accident and sickness as well as hospital expense benefits for you and all your eligible dependents.

PHYSICIANS CASUALTY & HEALTH ASSOCIATIONS
OMAHA 31, NEBRASKA

ALL PREMIUMS COME FROM PHYSICIANS SURGEONS DENTISTS ALL BENEFITS GO TO

Since 1902
Handsome Professional Appointment Book sent to you FREE upon request.

BAMADEX®
meprobamate 400 mg., with d-amphetamine sulfate 5 mg., Tablets
anorectic-ataractic

A logical combination for appetite suppression

meprobamate **plus** d-amphetamine...suppresses appetite...elevates mood... reduces tension...**without** insomnia, overstimulation or barbiturate hangover.

Dosage: One tablet one-half to one hour before each meal.

Lederle

contain
the
bacteria-prone
cold

TAIN

(Triacetyloleandomycin, Triaminic® and Calurin®)

inner
protection
with...

safe antibiosis

Triacetyloleandomycin, equivalent to oleandomycin 125 mg. This is the URI antibiotic, clinically effective against certain antibiotic-resistant organisms.

fast decongestion

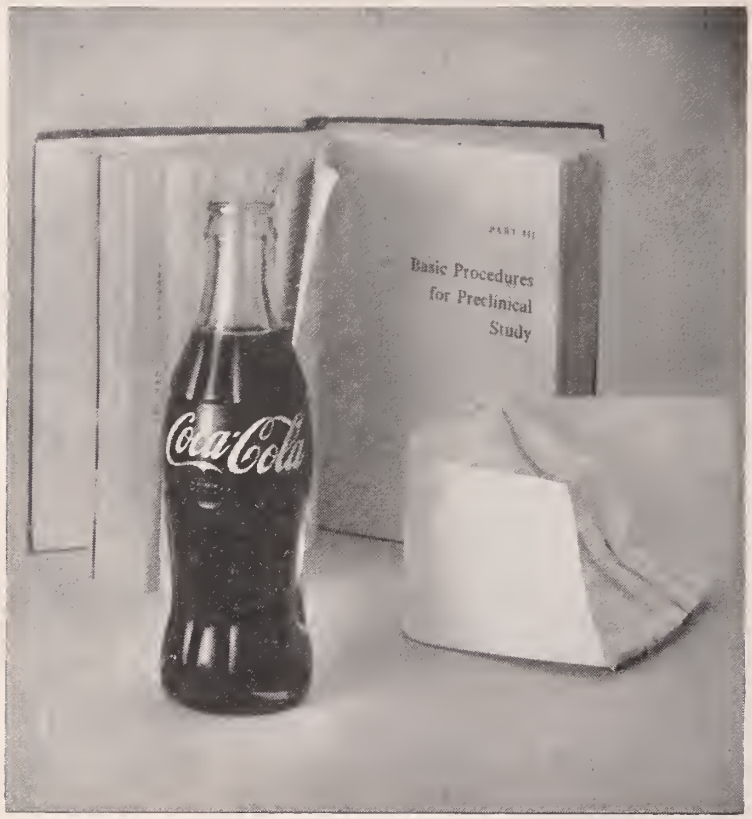
Triaminic®, 25 mg., three active components stop running noses. Relief starts in minutes, lasts for hours.

well-tolerated analgesia

Calurin®, calcium acetylsalicylate carbamide equivalent to aspirin 300 mg. This is the freely-soluble calcium aspirin that minimizes local irritation, chemical erosion, gastric damage. High, fast blood levels.

TAIN brings quick, symptomatic relief of the common cold (malaise, headache, muscular cramps, aches and pains) especially when susceptible organisms are likely to cause secondary infection. Usual adult dose is 2 Inlay-Tabs, q.i.d. In bottles of 50. ℞ only. Remember, to contain the bacteria-prone cold...TAIN.

SMITH-DORSEY · Lincoln, Nebraska
a division of The Wander Company



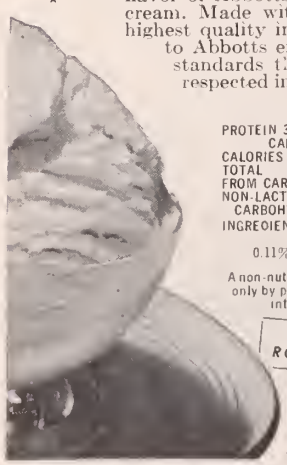
When too many tasks
seem to crowd
the unyielding hours,
a welcome
"pause that refreshes"
with ice-cold Coca-Cola
often puts things
into manageable order.

DRINK
Coca-Cola
REG. U.S. PAT. OFF.

NOW! DIABETICS CAN ENJOY
(UNDER MEDICAL ADVICE)

Abbotts
ARTIFICIALLY SWEETENED
ICE CREAM

Your patients whose sugar intake is restricted will relish the extra delicious flavor of Abbotts new, sugar-free ice cream. Made with infinite care and highest quality ingredients according to Abbotts exacting standards—standards that are most highly respected in the dairy industry.



COMPOSITION

PROTEIN 3.52%	MILK FAT 10.52%	
CARBOHYDRATES 21.35%		
CALORIES PER OUNCE	AVOIR.	FLUID
TOTAL	55.02	33.31
FROM CARBOHYDRATES	24.21	14.66
NON-LACTOSE CARBOHYDRATES	18.03	10.92

INGREDIENTS: CREAM, MILK, SORBITOL, STABILIZER AND 0.11% CYCLAMATE CALCIUM*

A non-nutritive artificial sweetener for use only by persons who must restrict their intake of ordinary sweets.

IN HANDY ROUND PINTS

At Abbotts
and Jane Logan Dealers
Abbotts Dairies, Inc.

A
logical
prescription for
overweight patients

anorectic-ataractic ®
BAMADEX
meprobamate 400 mg., with d-amphetamine sulfate 5 mg., Tablets

meprobamate **plus** d-amphetamine... depresses appetite...elevates mood... eases tensions of dieting...**without** over-stimulation, insomnia or barbiturate hangover.

Dosage: One tablet one-half to one hour before each meal.

Lederle

after milk and rest, why Donnalate?

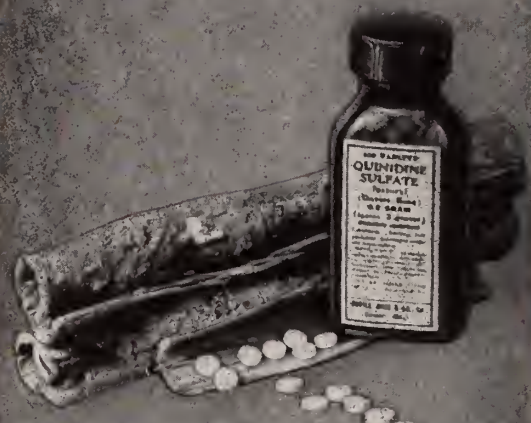
Once you've prescribed milk and rest for a peptic ulcer patient, Donnalate may be the best means for fulfilling his therapeutic regimen. This is because Donnalate combines several recognized agents which effectively complement each other and help promote your basic plan for therapy. A single tablet also simplifies medicine-taking.

in Donnalate: Dihydroxyaluminum aminoacetate affords more consistent neutralization than can diet alone. • Phenobarbital improves the possibility of your patient's resting as you told him to. • Belladonna alkaloids reduce GI spasm and gastric secretion. And by decreasing gastric peristalsis, they enable the antacid to remain in the stomach longer.

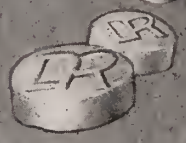
Each Donnalate tablet equals one Robalate® tablet plus one-half Donnatal® tablet: Dihydroxyaluminum aminoacetate, N. F., 0.5 Gm.; Phenobarbital (1/8 gr.), 8.1 mg.; Hyoscyamine sulfate, 0.0519 mg.; Atropine sulfate, 0.0097 mg.; Hyoscine hydrobromide, 0.0033 mg.

Donnalate®

A. H. Robins Co. INC.
RICHMOND 20, VIRGINIA



Of special significance to the physician is the symbol



When he sees it engraved on a Tablet of Quinidine Sulfate he has the assurance that the Quinidine Sulfate is produced from Cinchona Bark, is alkaloidally standardized, and therefore of unvarying activity and quality.

When the physician writes "DR" (Davies, Rose) on his prescriptions for Tablets Quinidine Sulfate, he is assured that this "quality" tablet is dispensed to his patient.

Rx Tablets Quinidine Sulfate Natural
0.2 Gram (or 3 grains)
Davies, Rose

Clinical samples sent to physicians on request

Davies, Rose & Company, Limited
Boston 18, Mass.

9-7

ANNUAL CLINICAL CONFERENCE

CHICAGO MEDICAL SOCIETY

FEBRUARY 28, MARCH 1, 2 and 3, 1961

Palmer House, Chicago

Lectures Teaching Demonstrations
Medical Color Telecasts
Instructional Courses

The Chicago Medical Society Annual Clinical Conference should be a MUST on the calendar of every physician. Plan now to attend and make your reservation at the Palmer House.

anorectic-ataractic

BAMADEX®

meprobamate 400 mg., with d-amphetamine sulfate 5 mg., Tablets

FOR THERAPY
OF OVERWEIGHT PATIENTS

- d-amphetamine depresses appetite and elevates mood
- meprobamate eases tensions of dieting (yet without overstimulation, insomnia or barbiturate hangover).

Dosage: One tablet one-half to one hour before each meal.

A LOGICAL COMBINATION
IN
APPETITE CONTROL

Lederle

CLASSIFIED ADVERTISEMENTS

WANTS FOR SALE TO LET

SITUATIONS ETC.

Send replies to box number c/o **The Journal** P. O. Box 904, Trenton 5, N. J.

$3.00 for 25 words or less: additional words 5c each Forms close 15th of the Preceding Month.

ANESTHESIOLOGIST—Available in January, desires location in New Jersey, preferably northeastern area. Write Box RO, c/o THE JOURNAL.

OBSTETRICIAN-GYNECOLOGIST—36, Board Certified, desires relocation. Seeking location for solo practice in growing community or association in New Jersey or New York. Write Box JR, c/o THE JOURNAL.

SURGEON—Board eligible, 31, veteran, excellent training traumatic and general surgery. Available immediately. Desires association or group affiliation. Mariash, No. 7 Park Ave., New York City.

INDUSTRIAL PHYSICIAN—Large Phila. industrial firm has immediate opening in its Medical Division for a physician to assist in the implementation of its Employe Medical Program. Headquarters in Phila. with some travel. Licensed or eligible for licensing in Penna. Send full details of education, experience, etc. to H. A. Smith, P. O. Box 7258, Phila. 1, Pa. All replies will be held in strictest confidence.

FOR RENT—HOBOKEN—Office for one or two physicians; two consultation rooms mahogany panelled with built-in bookshelves and cabinets; two examining rooms with built-in sinks, formica counters, glassed-wall cabinets; bath and stall shower; reception room with hall receptionist desk; quiet residential neighborhood; leaving for specialty. For information call P. Giordano, OLdfield 6-2854.

DOCTOR'S SUITE—in a modern, delux garden apartment. Golden opportunity for a physician. Completely air-conditioned and sound-proofed. No alterations are necessary. Ideal location in Millburn, N. J. Call MI. 2-2400 or WA. 6-0241.

NEW MEDICAL SUITES AVAILABLE in excellent location; at line of Hudson and Bergen Counties. One-story building with parking; all modern conveniences supplied. $160-$175/mos. Bergenline Professional Bldg., 8609 Bergenline Ave., North Bergen, N. J. UN. 9-0850.

UNUSUAL OPPORTUNITY—Professional Bldg., Montclair, New Jersey. Every advantage. Very low rental. Dr. Mearin—PI. 4-5657.

PLAINFIELD, N. J., 1310 West 7th St.—Two suites available, newly built professional building. Wood panelled waiting room, nurses' station, 3 examination rooms one suite, and 2 examination rooms the other suite. Private lavatories, central heating and air conditioning, on site parking. Rent reasonable. Call WAverly 6-3238. One suite now occupied by dentist.

PROFESSIONAL MEDICAL BUILDING—Business hub Pompton Lakes, New Jersey. Drawing area 125,000. Hospital in the vicinity. Daniel Motors, Inc., 261 Wanaque Ave., Pompton Lakes, N. J. Telephone—TEmple 5-2800.

SUMMIT OFFICE—Best location, spacious, well-arranged, redecorated; furnished equipped. Ideal for pediatrics, medicine, general; suitable any field. Adequate parking. Write Box WB, c/o THE JOURNAL.

FOR SALE—South Jersey shore area. Will sacrifice home, office, tremendous general practice for real estate value. Leaving for residency. High income assured. Will finance. Write Box FH, c/o THE JOURNAL.

HOME AND OFFICE FOR SALE—Retiring. Good terms, adjoining Newark, 10 miles from New York, large fully equipped office including x-ray; also room for dentist. Air conditioned. Two separate heating units. Elegant living quarters: 28' living room, 17' dining room, 3 bedrooms, wall-to-wall carpeting, eat-in kitchen, large expandable attic, full basement, 2-car garage. Contact: Edmund Lewandowski, M.D., 2 Smalley Terrace, Irvington, New Jersey. (population 75,000) ESsex 3-4648.

FOR SALE—Contents of G.P.'s office: x-ray machine and equipment, ECG Cardiathron, Diathermy Sanitex latest models, sunlamp, Detecto scales, furniture, etc. CHEAP! Call evenings or Sunday ES 2-6712.

one businessman has epilepsy...even his colleagues need not know—if his seizures are adequately controlled

Vith proper medication, epileptics may achieve success in a wide variety of professions.[1]

or improved seizure control

DILANTIN® SODIUM KAPSEALS® ...*outstandingly effective in grand mal and psychomotor seizures:* "DILANTIN *is an effective anticonvulsant which is useful in controlling epileptic attacks of any type with the exception of idiopathic petit mal.*"[2] "*It* DILANTIN] *is one of the few useful anticonvulsants in which oversedation is not a common problem when all therapeutic doses are employed.*"[3] DILANTIN Sodium *(diphenylhydantoin sodium, Parke-Davis) is available in several forms, including Kapseals of 0.03 Gm. and of 0.1 Gm., in bottles of 100 and 1,000.*

ther members of THE PARKE-DAVIS FAMILY OF ANTICONVULSANTS

or grand mal and psychomotor seizures: PHELANTIN® Kapseals *(Dilantin 100 mg., phenobarbital 30 mg., esoxyephedrine hydrochloride 2.5 mg.), bottles of 100. for the petit mal triad:* MILONTIN® Kapseals *(phenuximide, Parke-Davis) 0.5 Gm., bottles of 100 and 1,000; Suspension, 250 mg. per 4 cc., 16-ounce bottles* CELONTIN® Kapseals *(methsuximide, Parke-Davis) 0.3 Gm., bottles of 100.*

ITERATURE SUPPLYING DETAILS OF DOSAGE AND ADMINISTRATION AVAILABLE ON REQUEST.

1) Abraham, W., in Green, J. R., & Steelman, H. F.: Epileptic Seizures, Baltimore, Williams & Wilkins Company, 956, p. 132. (2) Crawley, J. W.: M. Clin. North America 42:317 *(March) 1958. (3) Bray, P. F.:* Pediatrics 23:151, *1959.*

PARKE-DAVIS

PARKE, DAVIS & COMPANY
Detroit 32, Michigan 27660

for your depressed dieters...

DEXAMYL® Spansule® capsules
Tablets · Elixir

brand of dextro amphetamine and amobarbital

In overweight, 'Dexamyl' helps your patients stick to their diets by

1. overcoming the depression which so often causes overeating

2. relieving the nervousness and irritability so frequently caused by strict reducing regimens

When listlessness and lethargy are problems in reducing, your patients will often benefit from the gentle stimulating effect of

DEXEDRINE® Spansule® capsules · Tablets · Elixir
brand of dextro amphetamine

Each 'Dexamyl' Spansule sustained release capsule (No. 2) contains 'Dexedrine' (brand of dextro amphetamine sulfate), 15 mg., and amobarbital, 1½ gr. Each 'Dexamyl' Spansule capsule (No. 1) contains 'Dexedrine', 10 mg., and amobarbital, 1 gr.
Each 'Dexedrine' Spansule sustained release capsule contains dextro amphetamine sulfate, 5 mg., 10 mg., or 15 mg.

SMITH KLINE & FRENCH

THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

Entered as second-class matter September 5, 1906, at the post office at Orange, New Jersey, under Act of March 3, 1879

Second Class Postage Paid at Orange, N. J.

Vol. 57, No. 11 — November, 1960 — Subscriptions, $3.00 per Year; Single Copies, 30 Cents

LIBRARY
NOV 21 1960
NEW YORK ACADEMY OF MEDICINE

CONTENTS—Pages 613 to 674

EDITORIALS— Page

- **Edward Zeh Hawkes, 1865-1960** — 613
- **Civic Service by M.D.s** — 614
- **Christmas Seals and the Hidden Invader** — 615

ORIGINAL ARTICLES—

- **Cigarette Smoking and Lung Cancer**—Max Finkelstein, M.D., Jersey City, N. J. — 616
- **Recent Advances in Dermatology**—Benjamin B. Burrill, M.D., Montclair, N. J. — 623
- **The Rokitansky-Aschoff Sinus**—Ralph A. Hall, M.D., Westfield, N. J. — 627
- **The Private Psychiatric Hospital in a General Medical Community**—Robert S. Garber, M.D., Belle Mead, N. J. — 630
- **Anesthesia Coverage in Obstetrical Service**—George P. Potekhen, M.D., Plainfield, N. J. — 634
- **Depression in Middle-Aged Patients**—John C. Whitaker, M.D., Riverton, N. J. — 636
- **Hyperbilirubinemia in the Newborn**—Albert Ehrlich, M.D., Hoboken, N. J. — 642
- **Surgical Research in 1960**—John H. Grindlay, M.D., Rochester, Minn. — 645

ORIGINAL ARTICLES— Page

- **Developmental Aspects of Retardation**—Werner Kornfeld, M.D., Ph.D., East Orange, N. J. — 649
- **Simple Method for Aspiration of the Chest**—G. A. Nitshe, Jr., M.D., Monroeville, N. J. — 653
- **Psychosomatic Factors in Constipation**—Sanford M. Lewis, M.D., Newark, N. J. — 654
- **Small Bowel Biopsy**—Abraham I. Friedman, M.D., Hackensack, N. J. — 658

STATE ACTIVITIES—

- Physician Increase in New Jersey — 641
- Trustees' Meeting: August 21, 1960 — 660
- Report of A.M.A. Delegates — 661
- Council on Legislation — 662
- F. B. I. Wants Cardiac Patient — 665
- New FACS Names for New Jersey — 665

ANNOUNCEMENTS — 666

COUNTY SOCIETY REPORTS — 667

OBITUARIES — 669

BOOK REVIEWS — 670

NTA ABSTRACTS — 673

Roster of Officers and Committee Chairmen, Advertising Page 3A

Place of Publication, Printing and Mailing, 116-118 Lincoln Ave., Orange, N. J.

Editorial and Executive Offices of the Society 315 West State St., Trenton 8, N. J.

Address all communications FOR PUBLICATION to editorial office at P.O. Box 904, Trenton 5, N. J.

Telephone EXport 4-3154

Published Monthly Since 1904

Acceptance for mailing at special rate of postage provided for in Sec. 1103, Act of Oct. 3, 1917, authorized July 29, 1918.

Copyright 1960 by
The Medical Society of New Jersey

State Medical Society Plans of Accident and Health Insurance Providing Coverage Up to $1,000 Monthly

THE MEDICAL SOCIETY OF NEW JERSEY officially selected the NATIONAL CASUALTY COMPANY in 1933 to underwrite its exclusively recognized group plan of accident and health insurance and officially selected the NATIONWIDE MUTUAL INSURANCE COMPANY in 1958 to underwrite its **additional** plan of accident and health insurance. Applications are invited from Society members who have not as yet applied; policies are available to applicants in accordance with Company rules and regulations for acceptance of risks.

BRIEF OUTLINE OF COVERAGE
NATIONAL CASUALTY COMPANY PLAN

(THE COMPLETE TERMS OF THE INSURANCE COVERAGE ARE SET FORTH IN THE POLICY)

ACCIDENTAL BODILY INJURY BENEFITS —Full monthly benefit for total disability, from FIRST DAY, limit 60 months. One-half monthly benefit for partial disability, limit 6 months. Limit of time for total and partial combined 60 months. (Total disability coverage extendable to lifetime.†)

SICKNESS BENEFITS —Full monthly benefit for total disability commencing with EIGHTH DAY of disability, limit 24 months, house confinement not required. (Total disability coverage extendable to 7 years.†)

(Regular care and attendance by a legally qualified physician or surgeon, other than yourself, required during period of disability.)

CONDITIONS OF RENEWABILITY —Once issued, the policy cannot be ridered for recurrent disability nor can it be terminated so long as the Society plan is in existence, except for non-payment of premium, if the insured retires or ceases to be actively engaged in the medical profession, if he ceases to be an active member of The Medical Society of New Jersey, or if renewal is refused on all policies issued to all members of the society, in which event 60 days prior notice in writing must be given.

EXCEPTIONS —Injury due to the hazards of warfare; suicide or intentionally self-inflicted injury, or any attempt thereat, while sane or insane; air travel, except passenger air travel as provided in the policy; all are not covered.

ANNUAL PREMIUM RATES*

(Applicable to ages at entry and attained at annual renewal of insurance)

Monthly Benefits	Dismemberment Benefits	Ages up to 50 Next Birthday	Ages 51 to 60 Next Birthday	Ages 61 to 65 ** Next Birthday
$100.00	$ 5,000	$ 29.50	$ 34.00	$ 43.00
150.00	7,500	43.60	50.35	63.85
200.00	10,000	57.70	66.70	84.70
300.00	15,000	85.90	99.40	126.40
400.00	20,000	114.10	132.10	168.10
500.00	20,000	141.30	163.80	208.80
‡ 600.00	20,000	168.50	195.50	249.50

* Premiums may be paid half-yearly or quarterly, pro-rata.

* All rates above INCLUDE $1000 Accidental Death Benefit.

** Although the age limit for acceptance of risks is the 65th birthday, once issued there is no termination age limit for renewal.

† Extension of sickness benefits to seven years and accident benefits for life available to holders of the above policy under age 60, in accordance with the company's underwriting regulations, through the EXTENDED PROFESSIONAL DISABILITY POLICY which is renewable to the 65th birthday. Ask about its coverage and modest additional cost.

‡ **ADDITIONAL BASIC COVERAGE UP TO $400 MONTHLY AVAILABLE THROUGH THE OFFICIALLY APPROVED NATIONWIDE MUTUAL INSURANCE COMPANY WITH SIMILAR RATES AND COVERAGE AND WHICH IS RENEWABLE TO AGE 70. Full details on all plans sent on request.**

NATIONAL CASUALTY COMPANY
through
E. and W. BLANKSTEEN

NATIONWIDE MUTUAL INSURANCE CO.
through
E. and W. BLANKSTEEN AGENCY, Inc.

75 MONTGOMERY STREET **DELAWARE 3-4340** **JERSEY CITY 2, N. J.**

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766

PLACE OF PUBLICATION, PRINTING AND MAILING, 116 LINCOLN AVE., ORANGE, N. J.

EXECUTIVE AND EDITORIAL OFFICES, 315 WEST STATE STREET, TRENTON 8, N. J. Tel. EXport 4-3154

(MAILING ADDRESS: P.O. BOX 904, TRENTON 5, N. J.)

Mr. Richard I. Nevin, *Executive Officer* ..... Trenton
Mrs. Edith L. Madden, *Administrative Secretary and Convention Manager* ..... Trenton
Henry A. Davidson, *Editor* ..... Cedar Grove
Mrs. Miriam N. Armstrong, *Assistant Editor* ..... Trenton

OFFICERS

President, Jesse McCall ..... Newton
President-Elect, Ralph M. L. Buchanan ..... Phillipsburg
First Vice-President, Louis S. Wegryn ..... Elizabeth
Second Vice-President, Carl N. Ware ..... Shiloh
Secretary, Marcus H. Greifinger ..... Newark
Treasurer, Daniel F. Featherston ..... Asbury Park

TRUSTEES

Luke A. Mulligan, *Chairman* (1962) ..... Leonia
Jerome G. Kaufman, *Secretary* (1961) ..... Newark
Jesse McCall ..... Newton
Ralph M. L. Buchanan ..... Phillipsburg
Louis S. Wegryn ..... Elizabeth
Carl N. Ware ..... Shiloh
Marcus H. Greifinger ..... Newark
Daniel F. Featherston ..... Asbury Park
F. Clyde Bowers ..... Mendham
David B. Allman (1962) ..... Atlantic City
John J. Bedrick (1963) ..... Bayonne
Nicholas A. Bertha (1962) ..... Wharton
C. Byron Blaisdell (1961) ..... Asbury Park
Louis K. Collins (1961) ..... Glassboro
Lloyd A. Hamilton (1962) ..... Lambertville
Frank J. Hughes (1963) ..... Gloucester
Joseph R. Jehl (1963) ..... Clifton
Samuel J. Lloyd (1963) ..... Trenton

COUNCILORS

First District (Union, Warren, Morris and Essex Counties) ..... Emanuel M. Satulsky, Elizabeth (1963)
Second District (Sussex, Bergen, Hudson and Passaic Counties) ..... John L. Olpp, Englewood (1962)
Third District (Mercer, Middlesex, Somerset and Hunterdon Counties) ..... Charles H. Calvin, Perth Amboy (1961)
Fourth District (Camden, Burlington, Ocean and Monmouth Counties) ..... E. Vernon Davis, Moorestown (1963)
Fifth District (Cape May, Cumberland, Atlantic, Gloucester and Salem Counties) ..... Isaac N. Patterson, Westville (1962)

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Delegates

C. Byron Blaisdell (1960) ..... Asbury Park
William F. Costello (1961) ..... Dover
Aldrich C. Crowe (1961 ..... Ocean City
J. Wallace Hurff (1960) ..... Newark
L. Samuel Sica (1960) ..... Trenton
Elmer P. Weigel (1960) ..... Plainfield

Alternates

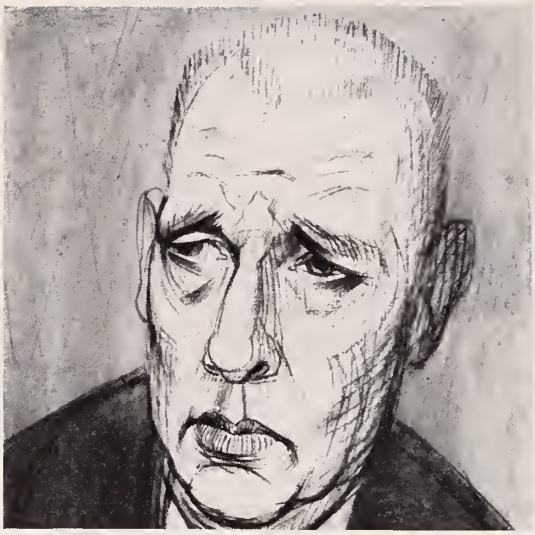
Ralph M. L. Buchanan (1960) ..... Phillipsburg
Joseph P. Donnelly (1961) ..... Jersey City
Elton W. Lance (1961) ..... Rahway
Jesse McCall (1960) ..... Newton
Herschel Pettit (1960) ..... Ocean City
John H. Rowland (1960) ..... New Brunswick

DELEGATES TO OTHER STATES

New York—William F. Costello (1961) ..... Dover
Connecticut—Lloyd A. Hamilton (1961) ..... Lambertville
New York—Levi M. Walker (1961) ..... Atlantic City
Connecticut—S. Eugene Dalton (1961) ..... Ventnor

COMMITTEE CHAIRMEN — 1960-61

Annual Meeting ..... Jerome G. Kaufman, Newark
Vice-Chairman—Edward E. P. Seidmon, Plainfield
Cancer Control ..... John L. Olpp, Englewood
Child Health ..... Robert E. Jennings, South Orange
Chronically Ill and Aging ..... William H. Hahn, Newark
Constitution and Bylaws ..... Louis F. Albright, Spring Lake
Vice-Chairman—Joseph M. Gannon, Plainfield
Credentials ..... M. H. Greifinger, Newark
Vice-Chairman—Eugene J. Tyrrell, Perth Amboy
Disaster Medical Services ..... R. Winfield Betts, Medford
Finance and Budget ..... David B. Allman, Atlantic City
Vice-Chairman—Carl N. Ware, Shiloh
Hearing and Speech ..... S. Eugene Dalton, Ventnor
Honorary Membership ..... Aldrich C. Crowe, Ocean City
Vice-Chairman—Royal A. Schaaf, Califon
Industrial Health ..... Willis B. Mitchell, Toms River
Legislation ..... C. Byron Blaisdell, Asbury Park
Vice-Chairman—A. Guy Campo, Westville
Maternal and Infant Welfare ..... John D. Preece, Trenton
Medical Defense and Insurance ..... Daniel F. Featherston, Asbury Park
Vice-Chairman—Benjamin F. Slobodien, Perth Amboy
Medical Education ..... Sherman Garrison, Jr., Bridgeton
Vice-Chairman—Morris H. Saffron, Passaic
Medical Services ..... Irving Klompus, Bound Brook
Vice-Chairman—Nicholas E. Marchione, Vineland
Medical Student Loan Fund ..... Luke A. Mulligan, Leonia
Vice-Chairman—Vincent P. Butler, Jersey City
Mental Health ..... John J. Mackin, Jersey City
Physicians Placement Service ..... Samuel J. Lloyd, Trenton
Publication ..... Fred B. Rogers, Trenton
Vice-Chairman—C. Spencer Davison, Salem
Public Health ..... Robert S. Garber, Belle Mead
Vice-Chairman—John B. Fuhrmann, Flemington
Public Relations ..... John F. Kustrup, Trenton
Vice-Chairman—John J. Torppey, Newark
Rehabilitation ..... Elmer J. Elias, Trenton
Scientific Exhibit ..... Milton Ackerman, Atlantic City
Scientific Program ..... Edward E. P. Seidmon, Plainfield
Traffic Safety ..... A. M K. Maldeis, Camden
Vision ..... Samuel M. Diskan, Atlantic City
Woman's Auxiliary ..... Lewis C. Fritts, Somerville
Vice-Chairman—A. Guy Campo, Westville
Workmen's Compensation ..... Joseph A. Lepree, Elizabeth



whenever depression complicates the picture

Tofrānil®
brand of imipramine HCl

hastens recovery

Geigy

In many seemingly mild physical disorders an element of depression plays an insidious etiologic or complicating role.

Because of its efficacy as an antidepressant, coupled with its simplicity of usage, Tofrānil is admirably adapted to use in the home or office in these milder "depression-complicated" cases.

It is always wise to recognize that depression may be an underlying factor...that Tofrānil may speed recovery in "hypochondriasis"; in convalescence when recovery is inexplicably prolonged; in chronic illness with dejection; in the menopausal patient whose emotional disturbances resist hormone therapy; and in many other comparable situations in which latent depression may play a part.

Detailed Literature Available on Request.

Tofrānil®, brand of imipramine hydrochloride, tablets of 25 mg. Ampuls for intramuscular administration, 25 mg. in 2 cc. of solution.

Geigy, Ardsley, New York

160-60

inner protection

Tain

(Triacetyloleandomycin, Triaminic® and Calurin®)

to contain the bacteria-prone cold

safe antibiosis

Triacetyloleandomycin, equivalent to oleandomycin 125 mg. This is the URI antibiotic, clinically effective against certain antibiotic-resistant organisms.

fast decongestion

Triaminic®, 25 mg., three active components stop running noses. Relief starts in minutes, lasts for hours.

well-tolerated analgesia

Calurin®, calcium acetylsalicylate carbamide equivalent to aspirin 300 mg. This is the freely-soluble calcium aspirin that minimizes local irritation, chemical erosion, gastric damage. High, fast blood levels.

TAIN brings quick, symptomatic relief of the common cold (malaise, headache, muscular cramps, aches and pains) especially when susceptible organisms are likely to cause secondary infection. Usual adult dose is 2 Inlay-Tabs, q.i.d. In bottles of 50. ℞ only. Remember, to contain the bacteria-prone cold...TAIN.

SMITH-DORSEY · LINCOLN, NEBRASKA

a division of The Wander Company

Use of pHisoHex for washing the skin augments any other therapy for acne — brings better results. Now, pHisoAc Cream, a new acne remedy for topical application, suppresses and masks lesions — dries, peels and degerms the skin. Together, pHisoHex and pHisoAc provide **basic** complementary topical therapy for acne.

pHisoHex, antibacterial detergent with 3 per cent hexachlorophene, removes soil and oil better than soap — provides **continuous** degerming action when used often. pHisoHex is nonalkaline, nonirritating and hypoallergenic.

When pHisoAc Cream is used with pHisoHex washings, it unplugs follicles, helps prevent development of comedones, pustules and scarring. New pHisoAc Cream is flesh-toned, not greasy. It contains colloidal sulfur 6 per cent, resorcinol 1.5 per cent, and hexachlorophene 0.3 per cent in a specially prepared base. pHisoAc is pleasant to use.

A new "self-help" booklet, **Teen-aged? Have acne? Feel lonely?**, gives important **psychologic first aid** for patients with acne and describes the proper use of pHisoHex and pHisoAc. Ask your Winthrop representative for copies.

pHisoAc is available in 1½ oz. tubes and pHisoHex is available in 5 oz. plastic squeeze bottles and in bottles of 16 oz.

pHisoHex® and pHisoAc for acne

trademark

Winthrop
LABORATORIES
New York 18, N. Y.

CHEMIPEN

Squibb Potassium Phenethicillin (Potassium Phenoxyethyl Penicillin)

ALL THE PHARMACOLOGIC ADVANTAGES, ALL THE THERAPEUTIC USEFULNESS OF CHEMICALLY IMPROVED PENICILLIN

Chemipen is Squibb's brand of phenethicillin potassium, the new advance in the biosynthesis of penicillin. When you prescribe Chemipen, you prescribe all the advantages of chemically improved penicillin.

Supply: Chemipen Tablets of 125 mg. (200,000 u.) and 250 mg. (400,000 u.), bottles of 24 and 100 tablets. Chemipen for Syrup (cherry-mint flavored, non-alcoholic), 125 mg. per 5 cc., 60 cc. bottles. For complete information consult package insert or write Professional Service Dept., Squibb, 745 Fifth Avenue, New York 22, N.Y. "CHEMIPEN" IS A SQUIBB TRADEMARK.

SQUIBB

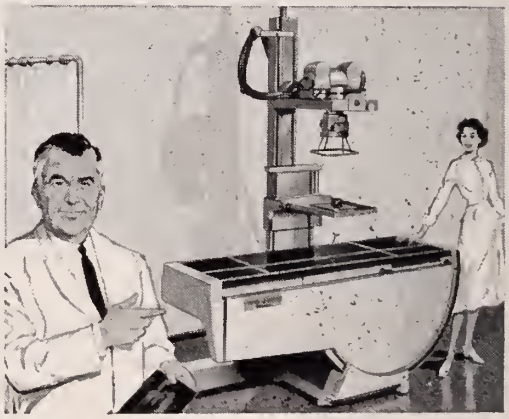
Squibb Quality—the Priceless Ingredient

Don't settle for "slow-power" x-ray

get a full 200-ma with your Patrician combination

When anatomical motion threatens to blur radiographs, the 200-ma Patrician can answer with extreme exposure speed, *twice* that of any 100-ma installation. Film images show improved diagnostic readability . . . retakes are fewer. And you'll find the G-E Patrician is like this in everything for radiography and fluoroscopy: built right, priced sensibly, *uncompromising* in assuring you all basic professional advantages. Full-size 81″ table . . . independent tubestand . . . shutter limiting device . . . automatic tube protection . . . counterbalanced fluoroscope, x-ray tube and Bucky . . . full-wave x-ray output.

You also can rent the Patrician—through G-E Maxiservice® x-ray rental plan. Gives you the complete x-ray unit, *plus* maintenance, parts, tubes, insurance, local taxes — *everything*—for one, uniform monthly fee. Get details from your local G-E x-ray representative listed below.



Progress Is Our Most Important Product

GENERAL ELECTRIC

DIRECT FACTORY BRANCHES

NEWARK
Springfield—52 Commerce St. • DRexel 9-4865

PHILADELPHIA
Hunting Pk. Ave. at Ridge • BAldwin 5-7600

THE ORIGINAL potassium phenethicillin

SYNCILLIN®

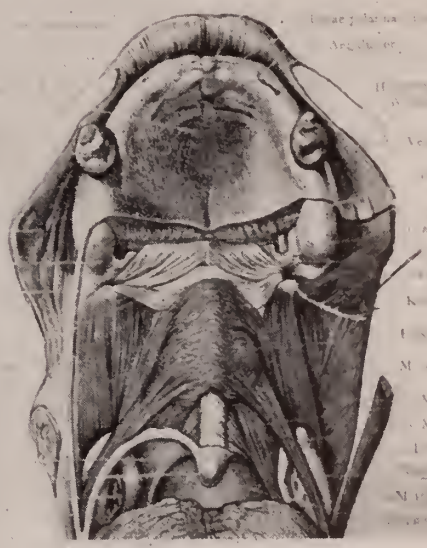
(phenoxyethyl penicillin potassium)

A dosage form to meet the individual requirements of patients of all ages in home, office, clinic, and hospital:

Syncillin Tablets — 250 mg. (400,000 units)...Syncillin Tablets — 125 mg. (200,000 units)
Syncillin for Oral Solution — 60 ml. bottles — when reconstituted, 125 mg. (200,000 units) per 5 ml.
Syncillin Pediatric Drops — 1.5 Gm. bottles. Calibrated dropper delivers 125 mg. (200,000 units)

Complete information on indications, ~~dosage and precautions~~ is included in the circular accompanying each package.

BRISTOL LABORATORIES, SYRACUSE, NEW YORK



Actual case summary from the files of Bristol Laboratories' Medical Department

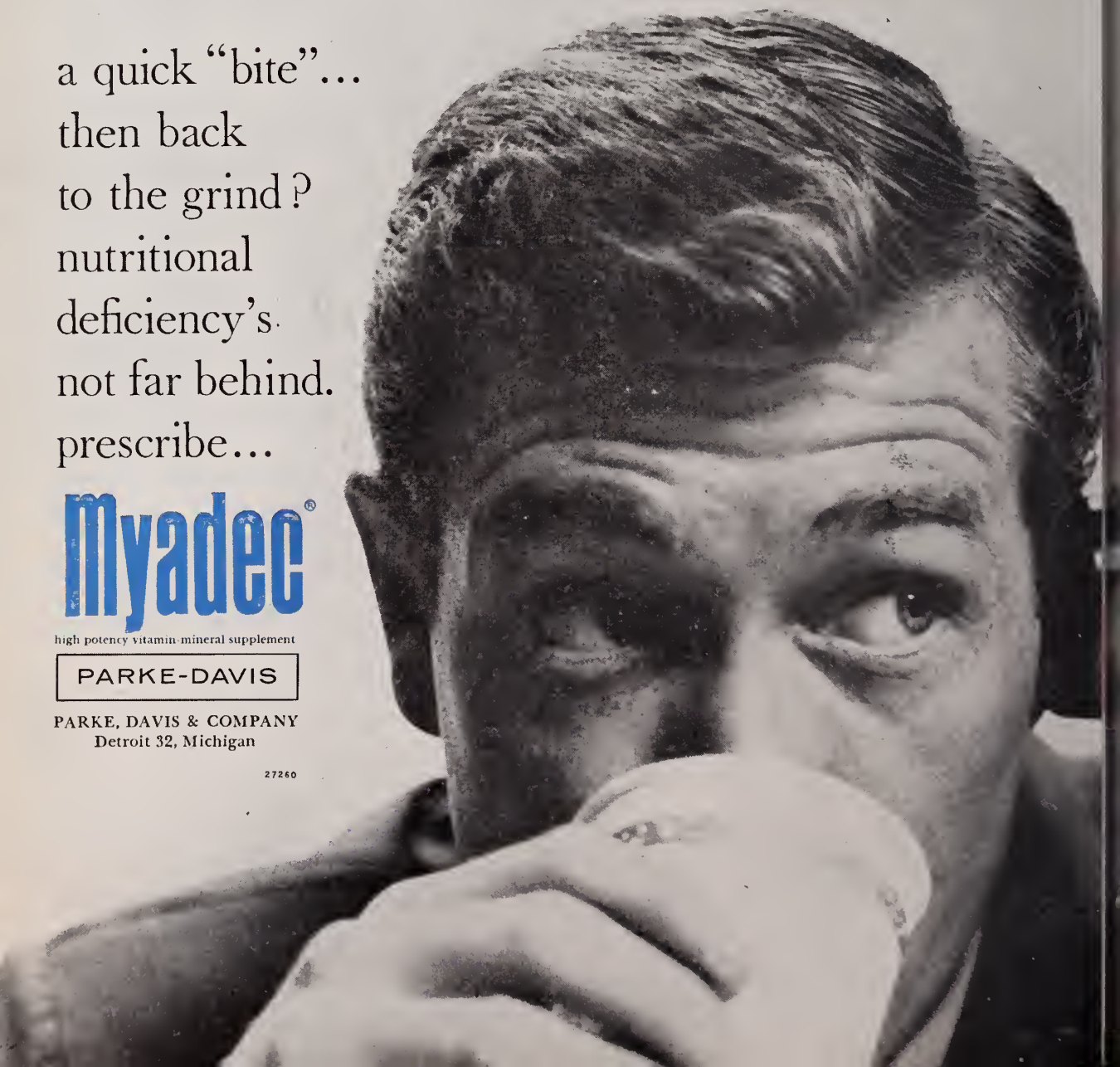
ACUTE TONSILLITIS

SYNCILLIN®
250 mg. q.i.d. — 5 days

B.G. 9-year-old, white male. First seen Aug. 11, 1959 with acute tonsillitis. Illness of 3 days' duration. Beta hemolytic streptococcus extremely sensitive to SYNCILLIN cultured from the throat. Patient started on SYNCILLIN — 250 mg. q.i.d. After 5 days, the infection appeared cured and the antibiotic was discontinued. No subjective or objective evidence of side reactions.

In active people who won't take time to eat properly, MYADEC can help prevent deficiencies by providing comprehensive vitamin-mineral support. Just one capsule a day supplies therapeutic doses of 9 important vitamins plus significant quantities of 11 essential minerals and trace elements. MYADEC is also valuable in vitamin depletion and stress states, in convalescence, in chronic disorders, in patients on salt-restricted diets, or wherever therapeutic vitamin-mineral supplementation is indicated.

Each MYADEC Capsule contains: VITAMINS: Vitamin B_{12} crystalline—5 mcg.; Vitamin B_2 (riboflavin)—10 mg.; Vitamin B_6 (pyridoxine hydrochloride)—2 mg.; Vitamin B_1 mononitrate—10 mg.; Nicotinamide (niacinamide)—100 mg.; Vitamin C (ascorbic acid)—150 mg.; Vitamin A—(7.5 mg.) 25,000 units; Vitamin D—(25 mcg.) 1,000 units; Vitamin E (d-alpha-tocopheryl acetate concentrate)—5 I.U. MINERALS: (as inorganic salts) Iodine—0.15 mg.; Manganese—1 mg.; Cobalt—0.1 mg.; Potassium—5 mg.; Molybdenum—0.2 mg.; Iron—15 mg.; Copper—1 mg.; Zinc—1.5 mg.; Magnesium—6 mg.; Calcium—105 mg.; Phosphorus—80 mg. Bottles of 30, 100 and 250.



if you're treating a coccal infection...

you can't prescribe a more effective antibiotic than ERYTHROCIN

Erythromycin, Abbott

How much "spectrum" do you need in treating an infection? Clearly, you want an antibiotic that will show the greatest activity against the offending organism, *and the least activity against non-pathogenic gastro-intestinal flora.*

Weigh these criteria—and make this comparison—when treating your next coccal infection. Erythrocin is a medium-spectrum antibiotic, notably effective against gram-positive organisms. In this it comes close to being a "specific" for coccal infections—*which means it is delivering a high degree of activity against the majority of common infection-producing bacteria.*

And against many of the troublesome "staph" strains—a group which shows increasing resistance to penicillin and certain other antibiotics—Erythrocin continues to provide bactericidal activity. Yet, as potent as Erythrocin is, *it rarely has a disturbing effect on normal gastro-intestinal flora.* Comes in easy-to-swallow Filmtabs®, 100 and 250 mg. Usual adult dose is 250 mg. every six hours. Children, in proportion to age and weight. Won't you try Erythrocin?

®Filmtab—Film-sealed tablets, Abbott.

ABBOTT

011299

Keep Spirits Up as WEIGHT GOES DOWN..

OBETROL®

Patent #2748052

for medical management of obesity

The **different** amphetamine combination of choice... even in many cases of hyperthyroidism, hypertension, coronary artery and other cardiovascular diseases.

- Safer
- Allays hunger
- Diuretic action
- Elevates mood
- Fewer contraindications
- Potent and effective

OBETROL incorporates the desired action of amphetamines without usual drawbacks.

OBETROL Each 20 mg. tablet or two 10 mg. tablets contain safer, longer acting Methamphetamine Saccharate 5 mg., with Methamphetamine Hydrochloride 5 mg., Amphetamine Sulfate 5 mg., Dextro Amphetamine Sulfate 5 mg.

SUPPLIED: in 10 mg. and 20 mg. tablets in bottles of 100, 500, and 1,000.

Ref: Plotz, M.: Modern Management of Obesity, J.A.M.A. 170: 1513-1515 (July 25) 1959.

Available on prescription at all leading pharmacies.

Write today for clinical samples.

REFER TO PDR Page 753

OBETROL PHARMACEUTICALS • 382 Schenck Avenue • Brooklyn 7, N. Y.

DECLOMYCIN®

DEMETHYLCHLORTETRACYCLINE LEDERLE

attains
sustains
retains

extra
antibiotic
activity

extra-activity...promptly attained

DECLOMYCIN Demethylchlortetracycline attains —usually within two hours—blood levels more than adequate to suppress susceptible pathogens. These levels are attained in tissues and body fluids on daily dosages substantially lower than those required to elicit antibiotic activity of comparable intensity with other tetracyclines. With other tetracyclines, the average, effective, adult daily dose is 1 Gm. With DECLOMYCIN Demethylchlortetracycline, it is only 600 mg.

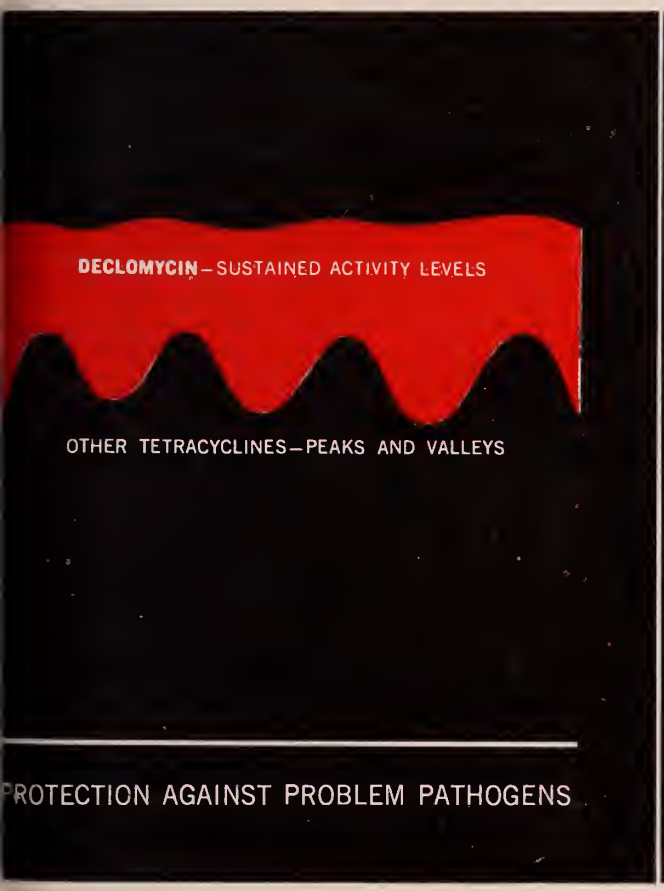
DECLO

evenly sustained

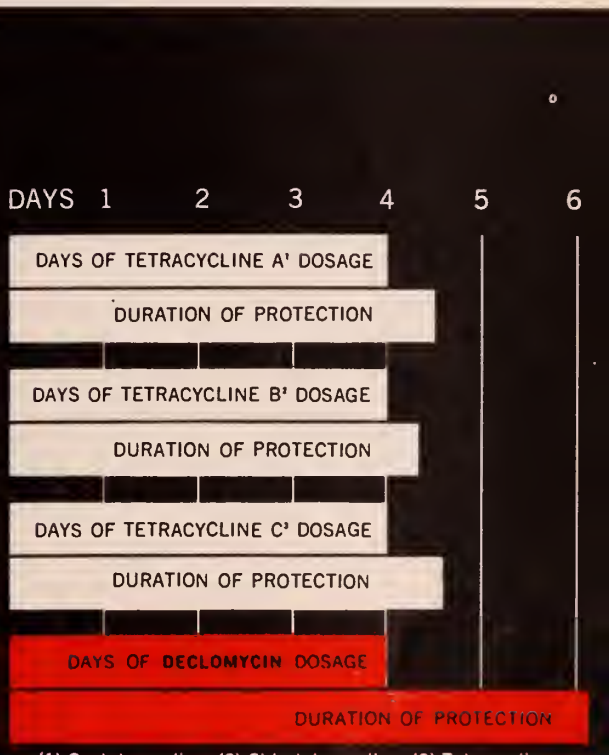
DECLOMYCIN Demethylchlortetracycline sustains, through the entire therapeutic course, the high activity levels needed to control the primary infective process and to check the onset of a complicating secondary infection at the original—or at another—site. This combined therapeutic action is sustained, in most instances, without the pronounced hour-to-hour, dose-to-dose, peak-and-valley fluctuations in activity levels which characterize other tetracyclines.

long retained

DECLOMYCIN Demethylchlortetracycline retains significant activity levels, up to 48 hours after the last dose is given. At least a full, extra day of positive antibacterial action may thus be confidently expected. One capsule four times a day, for the average adult in the average infection, is the same as with other tetracyclines—but the **total** dosage is lower and the duration of anti-infective action is longer.



PROTECTION AGAINST PROBLEM PATHOGENS



(1) Oxytetracycline. (2) Chlortetracycline. (3) Tetracycline.

PROTECTION AGAINST RECURRENCE

MYCIN®

DEMETHYLCHLORTETRACYCLINE LEDERLE

- higher activity/intake ratio—positive antibacterial action
- sustained activity levels—protection against problem pathogens
- up to two extra days' activity—protection against recurrence

CAPSULES, 150 mg., bottles of 16 and 100. **Dosage:** Average infections — 1 capsule four times daily. Severe infections—Initial dose of 2 capsules, then 1 capsule every six hours.
PEDIATRIC DROPS, 60 mg./cc. in 10 cc. bottle with calibrated, plastic dropper **Dosage:** 1 to 2 drops (3 to 6 mg.) per pound body weight per day—divided into 4 doses.
SYRUP, 75 mg./5 cc. teaspoonful (cherry-flavored), bottles of 2 and 16 fl. oz **Dosage:** 3 to 6 mg. per pound body weight per day—divided into 4 doses.

PRECAUTIONS: As with other antibiotics, DECLOMYCIN may occasionally give rise to glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis or dermatitis. A photodynamic reaction to sunlight has been observed in a few patients on DECLOMYCIN. Although reversible by discontinuing therapy, patients should avoid exposure to intense sunlight. If adverse reaction or idiosyncrasy occurs, discontinue medication.

Overgrowth of nonsusceptible organisms is a possibility with DECLOMYCIN, as with other antibiotics. The patient should be kept under observation.

for the added measure of protection in clinical practice

DECLOMYCIN®
DEMETHYLCHLORTETRACYCLINE LEDERLE

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

when pressure is a problem

Reduce pressure through bradycardic, tranquillizing action....

'Rauwistan'

the MRT-standardized Rauwolfia

BECAUSE its unique chemical and biological standardization assures uniformity and consistency of effect time after time with high activity and minimal incidence of side effects.

SUPPLIED: Tablets of 50 and 100 mg., in bottles of 100.

DOSAGE: 100 to 300 mg. daily, in divided doses.

Reduce pressure through bradycardic, tranquillizing plus direct hypotensive action....

'Verwolfia'

the MRT-standardized Rauwolfia-Veratrum

BECAUSE it adds to Rauwistan the specific hypotensive effect of uniquely standardized Veratrum and assures uniformity and consistency of effect time after time with high activity and minimal incidence of side effects.

SUPPLIED: 50 mg. of Rauwolfia serpentina and of Veratrum viride (standardized whole root) in each tablet; in bottles of 50 and 100.

DOSAGE: 1 to 3 tablets daily for the first 2 or 3 days; then 1 or 2 tablets daily, as required.

MRT *M. R. Thompson, Inc.* Cranford, N. J.

RELIEVE ALL COMMON COLD SYMPTOMS AT ONCE

WITH

'EMPRAZIL'®

THE TOTAL COLD-THERAPY TABLET

nasal decongestant · analgesic antipyretic · antihistamine

The ingredients combined in each 'Emprazil' tablet provide multiple drug action for prompt symptomatic relief of aches, pains, fever and respiratory congestion—due to common colds, flu or grippe—without gastric irritation.

Dosage: Adults and older children—One or two tablets t.i.d. as required. Children 6 to 12 years of age—One tablet t.i.d. as required.

Supplied: Bottles of 100 or 1000

Each orange and yellow layered tablet contains:

'Sudafed'® brand Pseudoephedrine Hydrochloride	20 mg.
'Perazil'® brand Chlorcyclizine Hydrochloride	15 mg.
Acetophenetidin	150 mg.
Aspirin (Acetylsalicylic Acid)	200 mg.
Caffeine	30 mg.

Complete literature available on request.

BURROUGHS WELLCOME & CO.
(U.S.A.) INC., Tuckahoe, N. Y.

Blood pressure that goes up with stress often comes down with SERPASIL®

(reserpine CIBA)

One reason that many cases of hypertension respond to Serpasil is that many cases are associated with stress. Stress situations produce stimuli which pass through the sympathetic nerves, constricting blood vessels, and increasing heart rate. Hyperactivity of the sympathetic nervous system may elevate blood pressure; if prolonged, this may produce frank hypertension. By blocking the flow of excessive stimuli to the sympathetic nervous system, Serpasil guards against stress-induced vasoconstriction, brings blood pressure down slowly and gently.

In mild to moderate hypertension, Serpasil is basic therapy, effective alone "...in about 70 per cent of cases..."*

In severe hypertension, Serpasil is valuable as a primer. By adjusting the patient to the physiologic setting of lower pressure, it smooths the way for more potent antihypertensives.

In all grades of hypertension, Serpasil may be used as a background agent. By permitting lower dosage of more potent antihypertensives, Serpasil minimizes the incidence and severity of their side effects.

CIBA
SUMMIT, N. J.

*Coan, J. P., McAlpine, J. C., and Boone, J. A.: J. South Carolina M. A. 51:417 (Dec.) 1955.

Complete information available on request.

now–for more comprehensive control of

'pain & spasm'

INDICATIONS

HEAD: temporomandibular muscle spasm • NECK: acute torticollis, osteoarthritis of cervical spine with spasm of cervical muscles, whiplash injury • TRUNK AND CHEST: costochondritis, intercostal myositis, xiphodynia • BACK: acute and chronic lumbar strains and sprains, acute low back pain (unspecified), acute lumbar arthritis and traumatic injury, compression fracture, herniated intervertebral disc, post-disc syndrome, strained muscle(s) • EXTREMITIES: acute hip injury with muscle spasm, ankle sprain, arthritis (as of foot or knee), blow to shin followed by muscle spasm, bursitis, spasm or strain of muscle or muscle group, old fracture with recurrent spasm, Pellegrini-Stieda disease, tenosynovitis with associated pain and spasm.

-pain due to or associated with -spasm of skeletal muscle

a new muscle relaxant-analgesic

Robaxisal®

ROBAXIN® WITH ASPIRIN

Many conditions, painful in themselves, often give rise to spasm of skeletal muscles. ROBAXISAL, the new dual-acting muscle relaxant-analgesic, treats both the pain and the spasm with marked success: In clinical studies on 311 patients, 12 investigators[1] reported satisfactory results in 86.5%. Each ROBAXISAL Tablet contains:

- A relaxant component — Robaxin* — widely recognized for its prompt, long-lasting relief of painful skeletal muscle spasm, with unusual freedom from undesired side effects . . . . . 400 mg.

*Methocarbamol Robins. U.S. Pat. No. 2770649.

- An analgesic component—aspirin—whose pain-relieving effect is markedly enhanced by Robaxin, and which has added value as an anti-inflammatory and anti-rheumatic agent . . . . (5 gr.) 325 mg.

SUPPLY: ROBAXISAL Tablets (pink-and-white, laminated) in bottles of 100 and 500.

Also available ROBAXIN Injectable, 1.0 Gm. in 10-cc. ampul. ROBAXIN Tablets, 0.5 Gm. (white, scored) in bottles of 50 and 500.

. . . or when anxiety accompanies pain and spasm: ROBAXISAL®-PH (Robaxin® with Phenaphen®). Sedative-enhanced analgesic and skeletal muscle relaxant Each two white-and-green laminated ROBAXISAL-PH tablets contain: methocarbamol 800 mg., plus the equivalent of one Phenaphen capsule (phenacetin 194 mg., acetylsalicylic acid 162 mg., hyoscyamine sulfate 0.031 mg., and ¼ gr. phenobarbital 16.2 mg.). Bottles of 100 and 500.

[1] Clinical reports in files of A. H. Robins Co., Inc., from: J. Allen, Madison, Wisc., B. Billow, New York, N. Y., B. Decker, Richmond, Va., C. Freeman, Jr., Augusta, Ga., R. B. Gordon, New York, N. Y., J. E. Holmblad, Schenectady, N. Y., L. Levy, New York, N. Y., N. Lobue, Chicago Heights, Ill., H. Nachman, Richmond, Va., A. Poindexter, Los Angeles, Cal., E. Rogers, Brooklyn, N. Y., K. H. Strong, Fairfield, Ia.

Robins

Additional information available upon request.

A. H. ROBINS CO., INC., Richmond 20, Virginia

Making today's medicines with integrity . . . seeking tomorrow's with persistence

Lifts depression..

You see an improvement within a few days
Thanks to your prompt treatment and the smooth action of Deprol, her depression is relieved and her anxiety and tension calmed – *often in a few days.* She eats well, sleeps well and soon returns to her normal activities.

as it calms anxiety!

Smooth, balanced action lifts depression as it calms anxiety... rapidly and safely

Balances the mood — no "seesaw" effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient —*they often aggravate anxiety and tension.*

And although amphetamine-barbiturate combinations may counteract excessive stimulation—*they often deepen depression.*

In contrast to such "seesaw" effects, Deprol's smooth, *balanced* action lifts depression as it calms anxiety—both at the same time.

Acts swiftly — the patient often feels better, sleeps better, within a few days. Unlike the delayed action of most other antidepressant drugs, which may take two to six weeks to bring results, Deprol relieves the patient quickly — often within a few days. Thus, the expense to the patient of long-term drug therapy can be avoided.

Acts safely — no danger of liver damage. Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function—frequently reported with other antidepressant drugs.

Bibliography *(13 clinical studies, 858 patients)*: **1.** Alexander, L. (35 patients): Chemotherapy of depression — Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. **2.** Bateman, J. C. and Carlton, H. N. (50 patients): Meprobamate and benactyzine hydrochloride (Deprol) as adjunctive therapy for patients with advanced cancer. Antibiotic Med. & Clin. Therapy 6:648, Nov. 1959. **3.** Beerman, H. M. (44 patients): The treatment of depression with meprobamate and benactyzine hydrochloride. Western Med. 1:10, March 1960. **4.** Bell, J. L., Tauber, H., Santy, A. and Pulito, F. (77 patients): Treatment of depressive states in office practice. Dis. Nerv. System 20:263, June 1959. **5.** Breitner, C. (31 patients): On mental depressions. Dis. Nerv. System 20:142, (Section Two), May 1959. **6.** Gordon, P. E. (50 patients): Deprol in the treatment of depression. Dis. Nerv. System 21:215, April 1960. **7.** Landman, M. E. (50 patients): Clinical trial of a new antidepressive agent. J. M. Soc. New Jersey. In press, 1960. **8.** McClure, C. W., Papas, P. N., Speare, G. S., Palmer, E., Slattery, J. J., Konefal, S. H., Henken, B. S., Wood, C. A. and Ceresia, G. B. (128 patients): Treatment of depression — New technics and therapy. Am. Pract. & Digest Treat. 10:1525, Sept. 1959. **9.** Pennington, V. M. (135 patients): Meprobamate-benactyzine (Deprol) in the treatment of chronic brain syndrome, schizophrenia and senility. J. Am. Geriatrics Soc. 7:656, Aug. 1959. **10.** Rickels, K. and Ewing, J. H. (35 patients): Deprol in depressive conditions. Dis. Nerv. System 20:364, (Section One), Aug. 1959. **11.** Ruchwarger, A. (87 patients): Use of Deprol (meprobamate combined with benactyzine hydrochloride) in the office treatment of depression. M. Ann. District of Columbia 28:438, Aug. 1959. **12.** Settel, E. (52 patients): Treatment of depression in the elderly with a meprobamate-benactyzine hydrochloride combination. Antibiotic Med. & Clin. Therapy 7:28, Jan. 1960. **13.** Splitter, S. R. (84 patients): Treatment of the anxious patient in general practice. J. Clin. & Exper. Psychopath. In press, April-June 1960.

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate. **Supplied:** Bottles of 50 light-pink, scored tablets. Write for literature and samples.

Deprol▲®

WALLACE LABORATORIES / *Cranbury, N. J.*

CD-2843

Dependable
Pain Reliever

Professional confidence in the uniformity, potency and purity of Bayer Aspirin is evidenced by ever increasing recommendation. Bayer Aspirin is the most widely accepted brand of analgesic the world has ever known.

We welcome your requests for samples of Bayer Aspirin and Flavored Bayer Aspirin for Children.

THE BAYER COMPANY, DIVISION OF STERLING DRUG INC., 1450 BROADWAY, NEW YORK 18, N.Y.

on the pathogenesis of pyelonephritis:

"An inflammatory reaction here [renal papillae] may produce sudden rapid impairment of renal function. One duct of Bellini probably drains more than 5000 nephrons. It is easy to see why a small abscess or edema in this area may occlude a portion of the papilla or the collecting ducts and may produce a functional impairment far in excess of that encountered in much larger lesions in the cortex."[1]

The "exquisite sensitivity"[2] of the medulla to infection (as compared with the cortex), highlights the importance of obstruction to the urine flow in the pathogenesis of pyelonephritis. "There is good cause to support the belief that many, perhaps most, cases of human pyelonephritis are the result of infection which reaches the kidney from the lower urinary tract."[3]

to eradicate the pathogens no matter the pathway

FURADANTIN®

brand of nitrofurantoin

High urinary concentration • Glomerular filtration plus tubular excretion • Rapid antibacterial action • Broad bactericidal spectrum • Free from resistance problems • Well tolerated—even after prolonged use • No cross resistance or cross sensitization with other drugs

Average Furadantin Adult Dosage: 100 mg. tablet q.i.d. with meals and with food or milk on retiring. *Supplied:* Tablets, 50 and 100 mg.; Oral Suspension, 25 mg. per 5 cc. tsp.

References: 1. Schreiner, G. E.: A.M.A. Arch. Int. M. **102**:32, 1958. 2. Freedman, L. R., and Beeson, P. B.: Yale J. Biol. & Med. **30**:406, 1958. 3. Rocha, H., et al.: Yale J. Biol. & Med. **30**:341, 1958.

NITROFURANS—a *unique* class of antimicrobials

EATON LABORATORIES, DIVISION OF THE NORWICH PHARMACAL COMPANY, NORWICH, N. Y.

chronic leg ulcer?

"many patients who had ulcers from one to eight years obtained complete healing in six to ten weeks."[1]

CHLORESIUM®

ointment

CHLORESIUM Ointment has long been recognized as a medication of choice for local treatment of chronic wounds and ulcerations.[1,2] This time-tested agent is noted for its ability to promote healthy granulation, encourage normal epithelization, relieve pain and inflammation, and deodorize malodorous lesions. Furthermore, a complete lack of irritating or sensitizing properties makes CHLORESIUM ideal for patient-use at home.

CHLORESIUM Ointment—0.5% water-soluble chlorophyll derivatives in a hydrophilic ointment base, in 1-oz. and 4-oz. tubes.

CHLORESIUM Solution—0.2% water-soluble chlorophyll derivatives in isotonic saline solution, in 2-oz. and 8-oz. bottles.

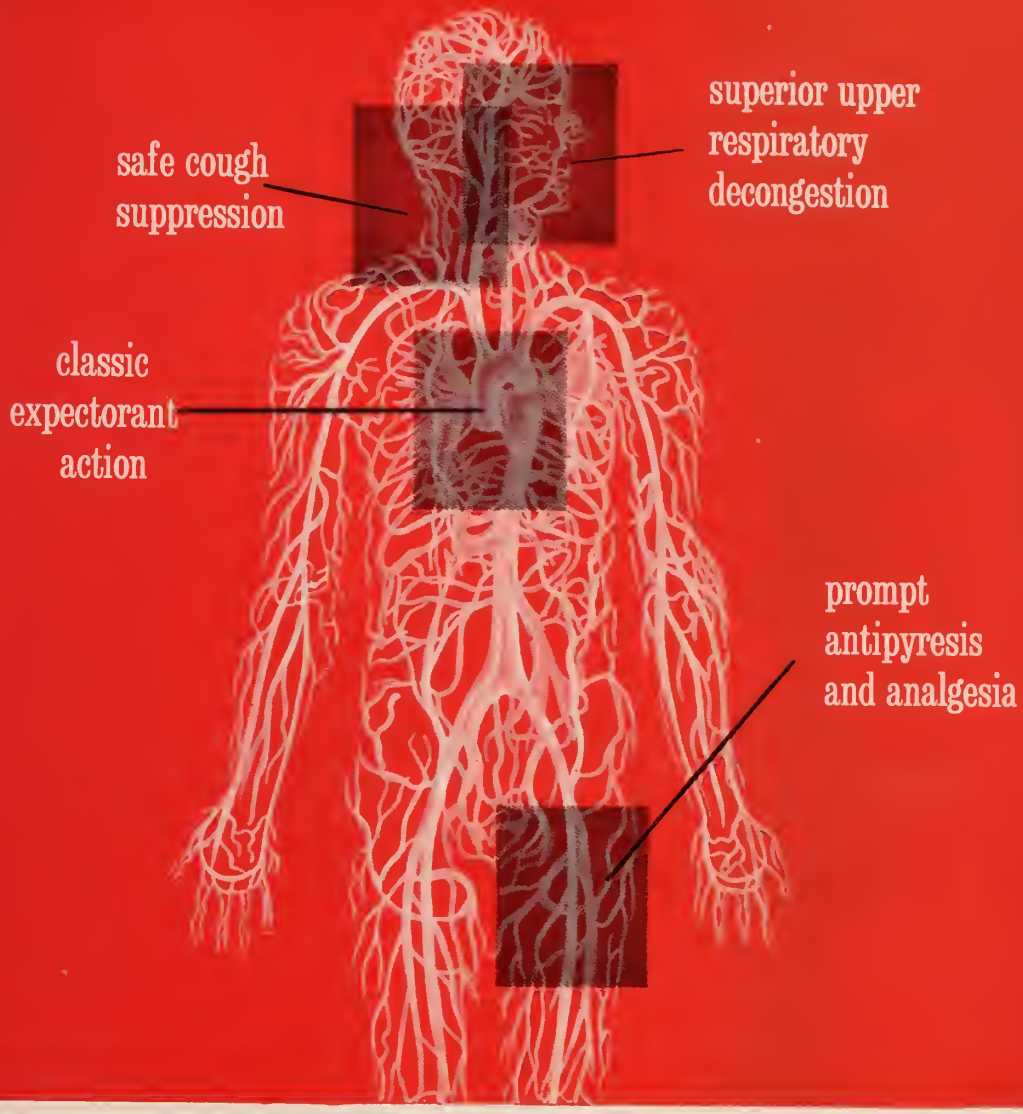
(1) Boehme, E. J.: Lahey Clin. Bull. **4**:242, 1946. (2) Diamond, O. K.: New York J. Med. **59**:1792, 1959.

Samples and literature available on request

Rystan Mount Vernon, N.Y.

34760

for relief from the total cold syndrome...



Tussagesic*

timed-release tablets / suspension

Each Tussagesic timed-release Tablet provides:

TRIAMINIC®	50 mg.
DORMETHAN (brand of dextromethorphan HBr)	30 mg.
TERPIN HYDRATE	180 mg.
APAP (acetaminophen)	325 mg.

Dosage: *Adults and children over 12* — one tablet in the morning, midafternoon and at bedtime. Each tablet should be swallowed whole to preserve the timed-release action.

Each tsp. (5 ml.) of Tussagesic Suspension provides:

TRIAMINIC®	25 mg.
DORMETHAN (brand of dextromethorphan HBr)	15 mg.
TERPIN HYDRATE	90 mg.
APAP (acetaminophen)	120 mg.

Tussagesic Suspension is especially suited for children and for adults who prefer liquid medication; it is pleasantly flavored, non-narcotic and non-alcoholic.

Dosage (to be taken every 3 or 4 hours): *Adults and children over 12* — 1 or 2 tsp.; *Children 6 to 12* — 1 tsp.; *Children 1 to 6* — ½ tsp.; *Children under 1* — ¼ tsp.

*TRADEMARK

SMITH-DORSEY ◦ a division of The Wander Company • Lincoln, Nebraska

for relief of hypertension

RUHEXATAL WITH RESERPINE

for

Rapid and Prolonged

BLOOD PRESSURE REDUCTION

RELIEF OF ANXIETY AND TENSION

Protection Against

CAPILLARY FRAGILITY

A therapeutic combination providing a safe, effective, long range treatment of hypertension with minimal side effects high patient acceptance and economy.

Each tablet contains Reserpine 0.1 mg. Mannitol Hexanitrate 30 mg. Rutin 20 mg. Ascorbic Acid 10 mg.

LEMMON PHARMACAL CO. SELLERSVILLE, PA.

1,928 published cases in the two years since TAO was released for general use show:

94.3% effectiveness in respiratory infections (617 cases including tonsillitis, staphylococcal and streptococcal pharyngitis, bronchitis, infectious asthma, broncho-pneumonia, lobar pneumonia, bronchiectasis, lung abscess, otitis.) **You can count on TAO.**

92% effectiveness in skin and soft tissue infections (900 cases including pyoderma, impetigo, acne, infected skin disorders, wounds, incisions and burns, furunculosis, abscess, cellulitis, chronic ulcer, adenitis.) **You can count on TAO.**

87.1% effectiveness in genitourinary infections (349 cases including urethritis, cystitis, pyelitis, pyelonephritis, orchitis, pelvic inflammation, acute gonococcal urethritis, lymphogranuloma venereum.) **You can count on TAO.**

75.8% effectiveness in diverse infections (62 cases including fever of undetermined origin, peritoneal abscess, osteitis, periarthritis, septic arthritis, staphylococcal enterocolitis, gastroenteritis, carriers of staphylococci.) **You can count on TAO.**

95.6% of 1,928 cases free of side effects—in the remaining 4.4%, reactions were chiefly mild gastrointestinal disturbances which seldom necessitated discontinuance of therapy.

*In 884 of 1,928 cases the causative organisms were mostly staphylococci. The majority of clinical isolates were found to be resistant to at least one of the commonly used antibiotics and many patients had failed to respond to previous therapy with one or more antibiotics. **TAO proved 93.4% effective in these 884 cases.**

Complete bibliography available on request.

DOSAGE: varies according to severity of infection. Usual adult dose—250 to 500 mg. q.i.d. Usual pediatric dose: 3-5 mg./lb. body weight every 6 hours.

NOTE: In some children, when TAO was administered at considerably higher than therapeutic levels for extended periods, transient jaundice and other indications of liver dysfunction have been noted. A rapid and complete return to normal occurred when TAO was withdrawn.

SUPPLY: TAO CAPSULES—250 mg. and 125 mg., bottles of 60. TAO ORAL SUSPENSION—125 mg. per 5 cc. when reconstituted, palatable cherry flavor, 60 cc. bottles. TAO PEDIATRIC DROPS—100 mg. per cc. when reconstituted, flavorful; special calibrated dropper, 10 cc. bottles. INTRAMUSCULAR or INTRAVENOUS—10 cc. vials, as oleandomycin phosphate.

OTHER TAO FORMULATIONS ALSO AVAILABLE: TAO®-AC (Tao, analgesic, antihistaminic compound) capsules, bottles of 36. TAOMID® (Tao with Triple Sulfas)—tablets, bottles of 60. Oral Suspension—60 cc. bottles.

For nutritional support **VITERRA®** Vitamins and Minerals
Formulated from Pfizer's line of fine pharmaceutical products.

ROERIG Rx
New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being™

in arthritis and allied disorders

Butazolidin®
brand of phenylbutazone
Geigy

Proved by a Decade of Experience
Confirmed by 1700 Published Reports
Attested by World-Wide Usage

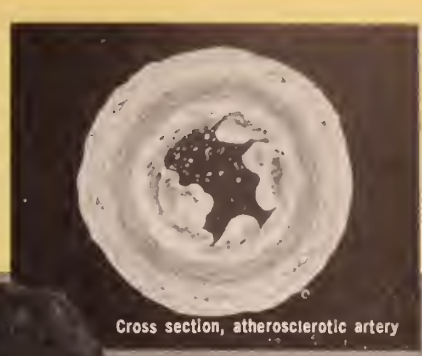
Since its anti-inflammatory properties were first noted in Geigy laboratories 10 years ago, time and experience have steadily fortified the position of Butazolidin as a leading nonhormonal anti-arthritic agent. Indicated in both chronic and acute forms of arthritis, Butazolidin is noted for its striking effectiveness in relieving pain, increasing mobility and halting inflammatory change.

Butazolidin®, brand of phenylbutazone: Red, sugar-coated tablets of 100 mg. Butazolidin® Alka: Orange and white capsules containing Butazolidin 100 mg.; dried aluminum hydroxide gel 100 mg.; magnesium trisilicate 150 mg.; homatropine methylbromide 1.25 mg.

Geigy, Ardsley, New York

162-60

outstanding nutritional research achievement


Cross section, atherosclerotic artery

to aid in the dietary control of serum cholesterol

MAZOLA®

MARGARINE
scientifically formulated with pure liquid non-hydrogenated MAZOLA Corn Oil.

MAZOLA Margarine is an economical tablespread and serves as a solid shortening, rich in linoleic acid and low in the more saturated fatty acids — making it an ideal dietary adjunct in the management of serum cholesterol. It contains 2 to 3 times as much linoleic acid as any other margarine in the grocery store, and 5 to 8 times as much as butter. It contains no dairy or animal fats, no coconut oil, and no cholesterol.

MAZOLA Margarine is indistinguishable from other quality margarines as to taste, aroma and handling characteristics. Thus, it can be part of the regular diet for the whole family, including the hypercholesterolemic patient. The major ingredient in MAZOLA Margarine — liquid MAZOLA Corn Oil—is NOT hydrogenated, thereby preserving its rich content of linoleates.

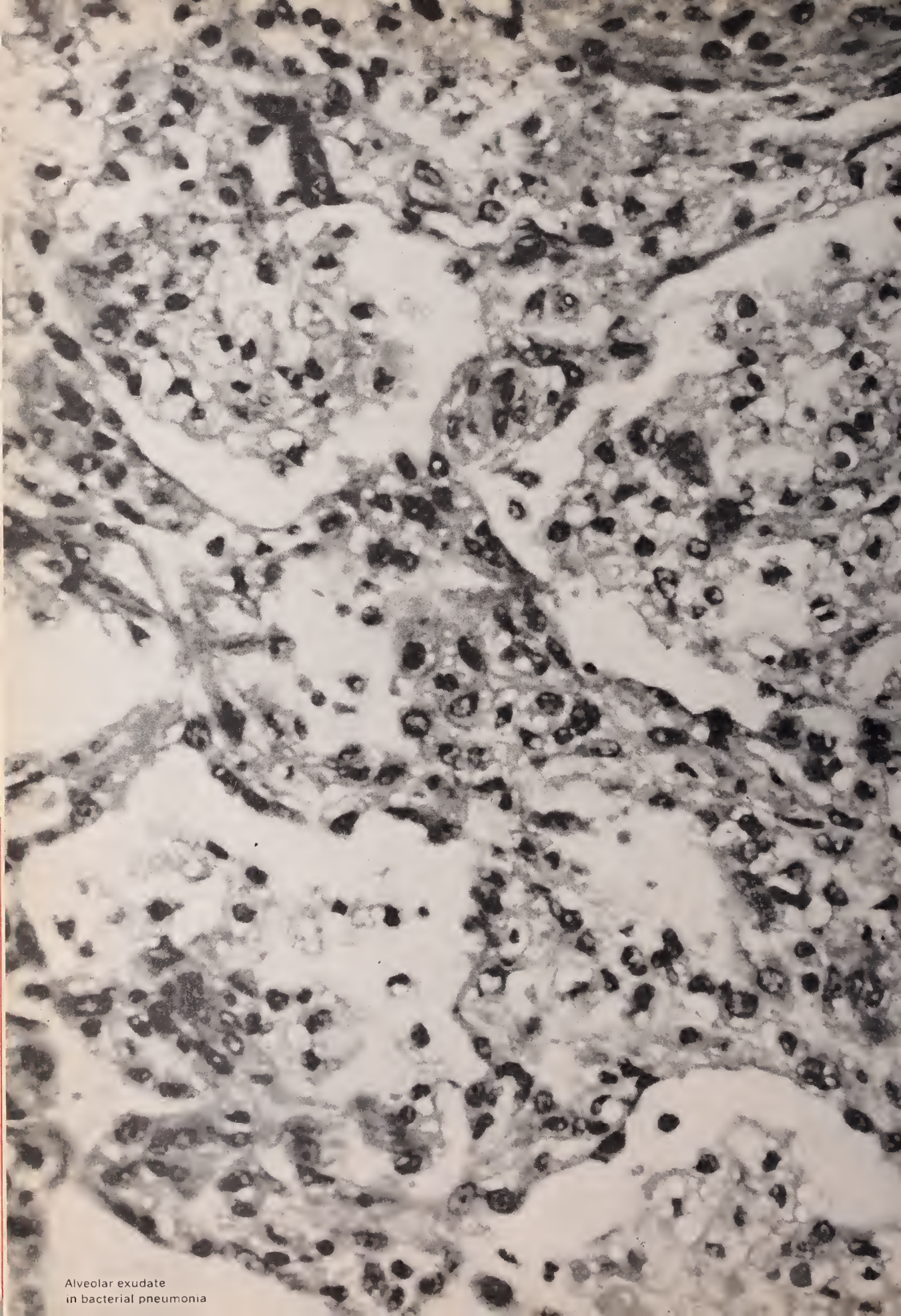
Two ounces or 56.8 Gm. (4 tablespoons) of MAZOLA Margarine supply:

Linoleic acid	12 Gm.
Oleic acid	23 Gm.
Saturated fatty acids	8 Gm.
Plant sterols (sitosterols)	215 mg.
Natural tocopherols	30 mg.
Vitamin A	1870 USP units
Vitamin D	250 USP units
Calories	415

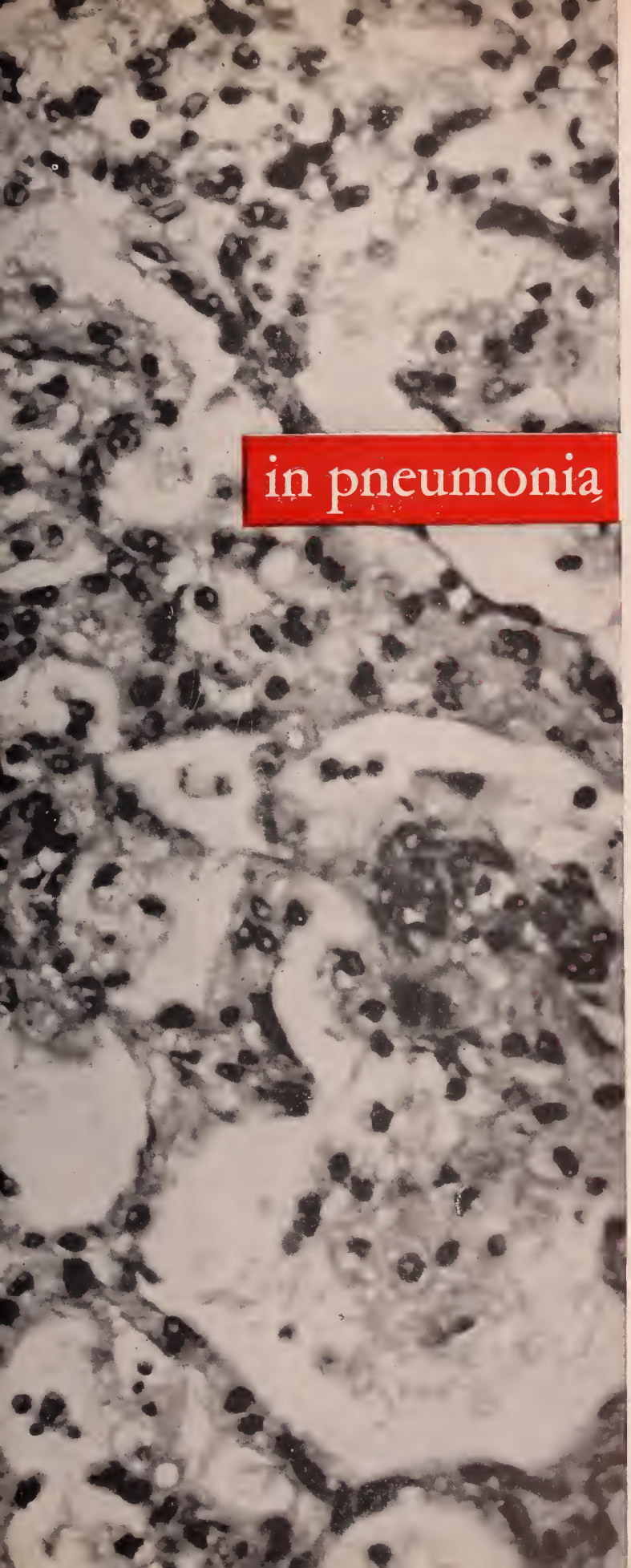
Available in the refrigerator sections of grocery stores in the same general price range as other premium quality margarines, in 1-lb. packages (four ¼ lb. sticks).

Send for free booklet:
"Recent Advances in the Dietary Control of Hypercholesterolemia."

BEST FOODS • Division of Corn Products Co., NEW YORK 22, N. Y.



Alveolar exudate
in bacterial pneumonia



Therapeutic confidence

Panalba is effective against more than 30 commonly encountered pathogens including staphylococci resistant to other antibiotics. Right from the start, prescribing it gives you a high degree of assurance of obtaining the desired anti-infective action in this as in a wide variety of bacterial diseases.

Supplied: Capsules, each containing Panmycin* Phosphate (tetracycline phosphate complex), equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin,* as novobiocin sodium, in bottles of 16 and 100.

*Trademark. Reg. U. S. Pat. Off.

The Upjohn
Kalamazoo,

Upjo

Panalba*

your broad-spectrum antibiotic of *first* resort

CLINICAL REMISSION IN A "PROBLEM" ARTHRITIC

In disabling rheumatoid arthritis. A 62-year-old printer incapacitated for three years was started on DECADRON, 0.75 mg./day. Has lost no work-time since onset of therapy with DECADRON one year ago. Blood and urine analyses are normal, sedimentation rate dropped from 36 to 7. He is in clinical remission.*

New convenient b.i.d. alternate dosage schedule: the degree and extent of relief provided by DECADRON allows for b.i.d. maintenance dosage in many patients with so-called "chronic" conditions. Acute manifestations should first be brought under control with a t.i.d. or q.i.d. schedule.

Supplied: As 0.75 mg. and 0.5 mg. scored, pentagon-shaped tablets in bottles of 100. Also available as Injection DECADRON Phosphate. Additional information on DECADRON is available to physicians on request. DECADRON is a trademark of Merck & Co., Inc.

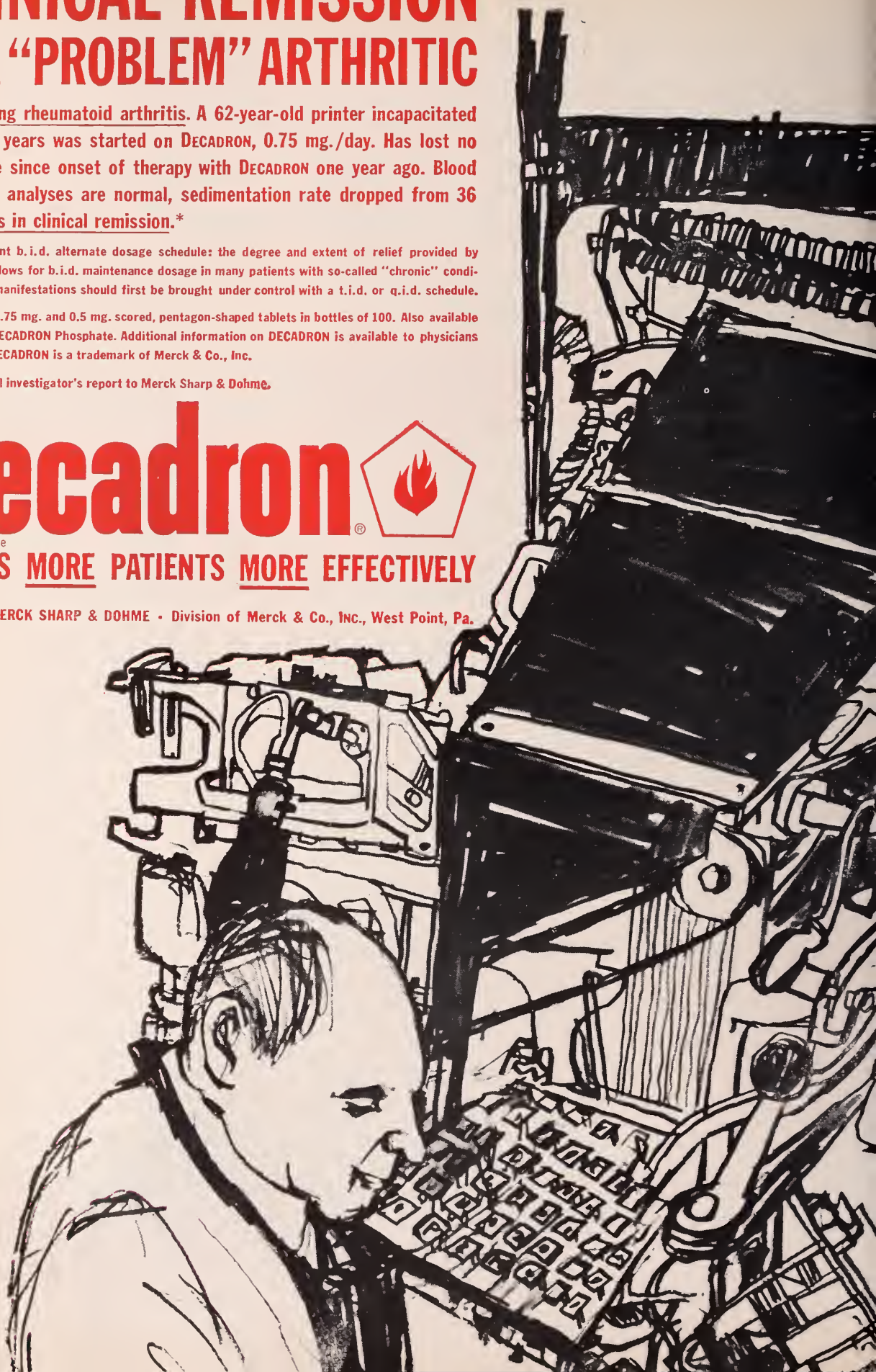
*From a clinical investigator's report to Merck Sharp & Dohme.

Decadron®

Dexamethasone

TREATS MORE PATIENTS MORE EFFECTIVELY

MSD MERCK SHARP & DOHME · Division of Merck & Co., Inc., West Point, Pa.



SALUTENSIN™

Hydroflumethiazide • Reserpine • Protoveratrine A

An integrated multi-therapeutic antihypertensive, that combines in balanced proportions three clinically proven antihypertensives.

In each **SALUTENSIN** Tablet:

Saluron® (hydroflumethiazide)—
a saluretic-antihypertensive ..... 50 mg.

Reserpine—a tranquilizing drug with
peripheral vasorelaxant effects ..... 0.125 mg.

Protoveratrine A—a centrally mediated
vasorelaxant ..... 0.2 mg.

Comprehensive information on dosage and precautions in official package circular or available on request.

BRISTOL LABORATORIES • Syracuse, New York

Simple Diet Changes

can help control serum cholesterol

Fortunately for the patient's morale — often all that is necessary when you want to prescribe a regimen to reduce serum cholesterol is to . . .

1. control the amount of calories and the type of dietary fat . . . and
2. make a simple modification in the method of food preparation, using poly-unsaturated vegetable oil in place of saturated fats

Obviously, in any special diet, the fewer required changes in the patient's eating habits, the more likelihood there is that the patient will adhere to the prescribed diet.

After adjusting total fat and calorie intake, the si ple replacement of *saturated* fats (those used at t table and in cooking) with *poly*-unsaturated Wess makes possible a most subtle dietary change, conforms completely to therapeutic requiremen

Uniformity you can depend on. Wesson has poly-unsaturated content better than 50%. Only t lightest cottonseed oils of high iodine numb are selected for Wesson and no significant var tions in standards are permitted in the 22 exacti specifications required before bottling.

Wesson satisfies the most exacting appetit To be effective, a diet must be *eaten* by the patie

he majority of housewives prefer Wesson particu-
rly by the criteria of odor, flavor (blandness) and
ghtness of color. (Substantiated by sales leadership
or 59 years and reconfirmed by recent tests against
ie next leading brand with brand identification
emoved, among a national probability sample.)

*'oly-unsaturated Wesson is unsurpassed
y any readily available brand, where a
egetable (salad) oil is medically
ecommended for a cholesterol depres-
ant regimen.*

WESSON'S IMPORTANT CONSTITUENTS

Wesson is 100% cottonseed oil . . .	winterized and of selected quality
Linoleic acid glycerides (poly-unsaturated)	50-55%
Oleic acid glycerides (mono-unsaturated)	16-20%
Total unsaturated	70-75%
Palmitic, stearic and myristic glycerides (saturated)	25-30%
Phytosterol (Predominantly beta sitosterol)	0.3-0.5%
Total tocopherols	0.09-0.12%
Never hydrogenated—completely salt free	

Free Wesson recipes for delicious main dishes, desserts and salad dressings are available for your patients. Request quantity needed from The Wesson People, Dept. N, 210 Baronne St., New Orleans 12, La.

AN AMES CLINIQUICK®

CLINICAL BRIEFS FOR MODERN PRACTICE

WHAT LABORATORY PROCEDURES ARE INDICATED IN DIABETICS WITH URINARY TRACT INFECTIONS?

A urine culture is absolutely essential in the diabetic suspected of having a urinary tract infection since such infection is not always accompanied by pyuria. It is also essential to keep the urine free from sugar—as shown by frequent urine-sugar tests—for successful therapy.

Source: Harrison, T. R., *et al.:* Principles of Internal Medicine, ed. 3, New York, McGraw-Hill Book Co., 1958, p. 620.

the most effective method of routine testing for glycosuria...

color-calibrated

CLINITEST®

BRAND *Reagent Tablets*

the *standardized* urine-sugar test for reliable quantitative estimations

Urinary tract infections are about four times more frequent in the diabetic than in the non-diabetic. The prevention and treatment of urinary tract infections, as well as the avoidance of other complications of diabetes, are significantly more effective in the well-controlled diabetic. The patient should be impressed repeatedly with the importance of continued daily urine-sugar testing—especially during intercurrent illness—and warned of the consequences of relaxed vigilance.

"urine-sugar profile" With the new *Graphic Analysis Record* included in the CLINITEST Urine-Sugar Analysis Set (and in the tablet refills), daily urine-sugar readings may be recorded to form a graphic portrayal of glucose excretion most useful in clinical control.

- *motivates patient cooperation* through everyday use of Analysis Record
- *reveals at a glance day-to-day trends* and degree of control
- *provides a standardized color scale* with a complete range in the familiar blue-to-orange spectrum

94450

AMES
COMPANY, INC
Elkhart • Indiana
Toronto • Canada

guard against ketoacidosis
...test for ketonuria
for patient and physician use

ADDED SAFETY FOR DIABETIC CHILDREN

ACETEST® *Reagent Tablets*

KETOSTIX® *Reagent Strips*

specific for tension headache...

FIORINAL®

relieves pain, muscle spasm, nervous tension

rapid action · non-narcotic · economical

"We have found caffeine, used in combination with acetylsalicylic acid, acetophenetidin, and isobutylallylbarbituric acid, [Fiorinal] to be one of the most effective medicaments for the symptomatic treatment of headache due to tension."

Friedman, A. P., and Merritt, H. H.: J.A.M.A. *163*:1111 (Mar. 30) 1957.

vailable: Fiorinal Tablets and
w Form — Fiorinal Capsules

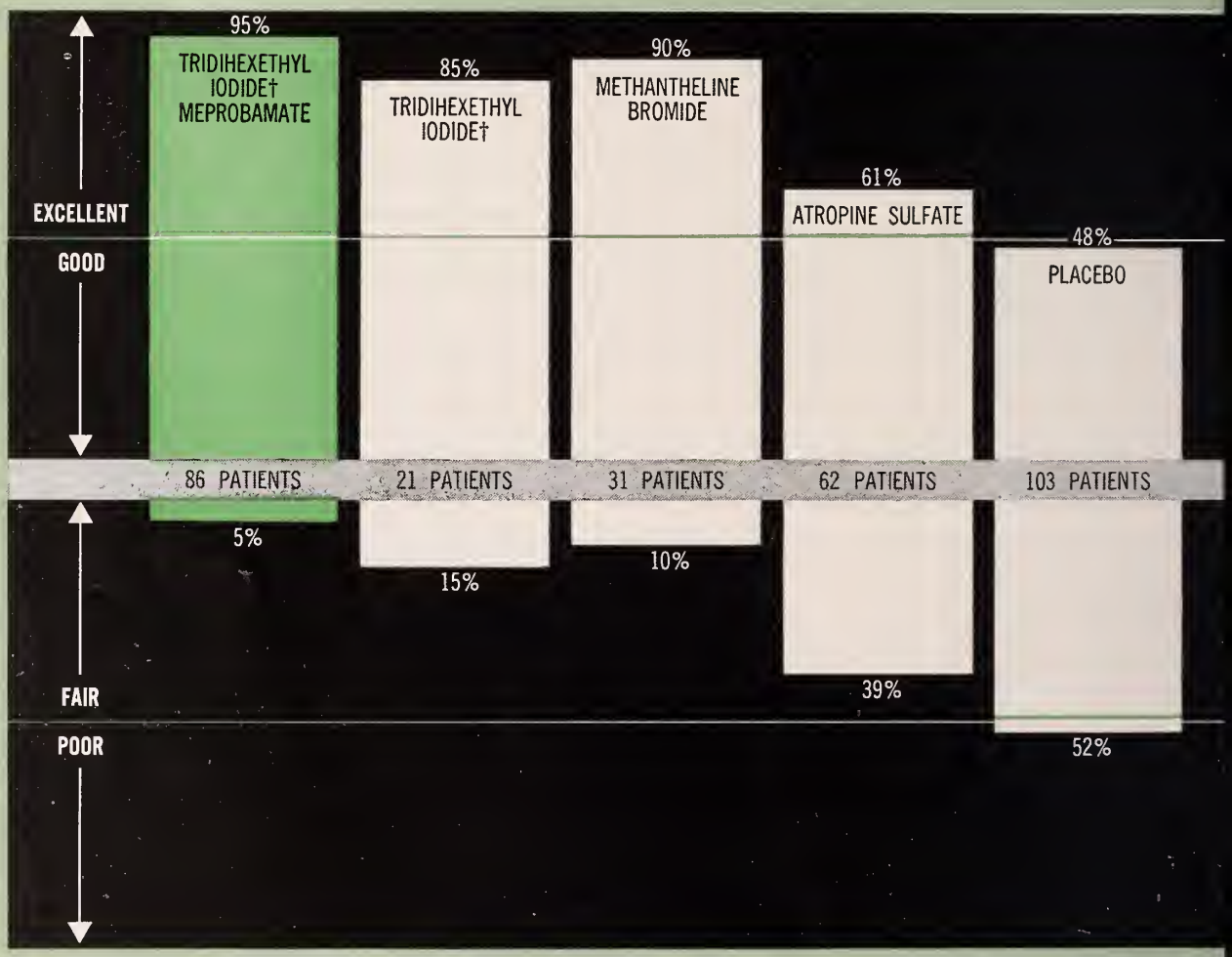
Each contains: Sandoptal (Allylbarbituric Acid N.F. X) 50 mg. (3/4 gr.), caffeine 40 mg. (2/3 gr.), acetylsalicylic acid 200 mg. (3 gr.), acetophenetidin 130 mg. (2 gr.).

Dosage: 1 or 2 every four hours, according to need, up to 6 per day.

SANDOZ

clinically proven efficacy

in relieving tension . . . curbing hypermotility and excessive secretion in G. I. disorders



PATHIBAMATE combines two highly effective and well-tolerated therapeutic agents:

Meprobamate—widely accepted tranquilizer and

PATHILON tridihexethyl chloride—anticholinergic noted for its effect on motility and gastrointestinal secretion with few unwanted side effects.

Contraindications: glaucoma, pyloric obstruction, and obstruction of the urinary bladder neck.

Two available dosage strengths permit adjusting therapy to the G.I. disorder and degree of associated tension.

Where a minimal meprobamate effect is preferred . . .
PATHIBAMATE-200 Tablets: 200 mg. of meprobamate; 25 mg. of PATHILON

Where a full meprobamate effect is preferred . . .
PATHIBAMATE-400 Tablets: 400 mg. of meprobamate; 25 mg. of PATHILON

Dosage: Average oral adult dose is 1 tablet t.i.d. at mealtime and 2 tablets at bedtime.

Pathibamate® 400 200

meprobamate with PATHILON® tridihexethyl chloride Lederle

clinically proven safety

The efficacy of **PATHIBAMATE** has been confirmed clinically in **duodenal ulcer, gastric ulcer, intestinal colic, spastic and irritable colon, ileitis, esophageal spasm, anxiety neurosis** with gastrointestinal symptoms, and **gastric hypermotility.**

Pictured are the results obtained with the PATHILON (tridihexethyl iodide)–meprobamate combination† in a double-blind study of 303 ulcer patients, extending over a period of 36 months.* They clearly demonstrate the efficacy of **PATHIBAMATE** in controlling the symptoms.

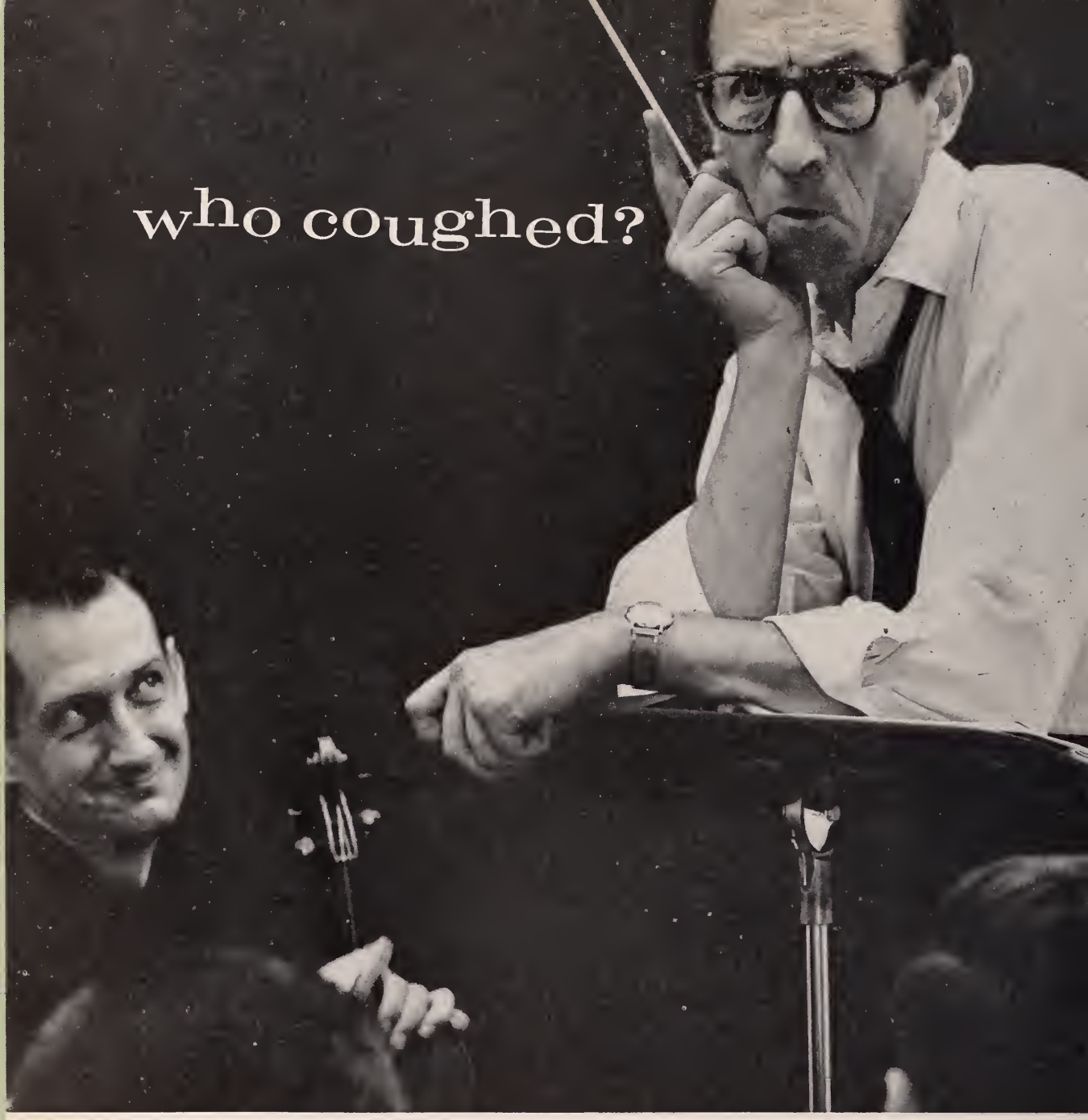
SIDE EFFECTS	TRIDIHEXETHYL IODIDE† MEPROBAMATE	TRIDIHEXETHYL IODIDE†	METHANTHELINE BROMIDE	ATROPINE SULFATE	PLACEBO
DRY MOUTH	1%	5%	72%	46%	5%
STOMATITIS	1%	0%	28%	14%	0%
VISUAL DISTURBANCES	0%	0%	50%	34%	1%
URINARY RETENTION	0%	0%	18%	11%	1%
DROWSINESS	20%	0%	0%	0%	0%
COMPLICATIONS OR SURGERY					
HEMORRHAGE	0%	9%	3%	9%	10%
PERFORATION	0%	0%	0%	6%	0%
OPERATION	0%	5%	5%	14%	2%
RECURRENCES					
NONE	28%	23%	25%	17%	26%
FEWER AND MILDER	67%	62%	52%	37%	24%
SAME OR MORE	5%	15%	23%	46%	50%

*Atwater, J. S., and Carson, J. M.: Therapeutic Principles in Management of Peptic Ulcer. Am. J. Digest. Dis. 4:1055 (Dec.) 1959.

†PATHILON is now supplied as tridihexethyl chloride instead of the iodide, an advantage permitting wider use, since the latter could distort the results of certain thyroid function tests.

Lederle LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

control the tension — treat the trauma



WHENEVER COUGH THERAPY IS INDICATED

HYCOMINE® Syrup

THE COMPLETE Rx FOR COUGH CONTROL

cough sedative / antihistamine decongestant / expectorant

■ relieves cough and associated symptoms in 15-20 minutes ■ effective for 6 hours or longer ■ promotes expectoration ■ rarely constipates ■ agreeably cherry-flavored

Each teaspoonful (5 cc.) of HYCOMINE* Syrup contains:

Hycodan®	
Dihydrocodeinone Bitartrate . . . . . 5 mg. (Warning: May be habit-forming)	6.5 mg.
Homatropine Methylbromide . . . . . 1.5 mg.	
Pyrilamine Maleate	12.5 mg.
Phenylephrine Hydrochloride	10 mg.
Ammonium Chloride	60 mg.
Sodium Citrate	85 mg.

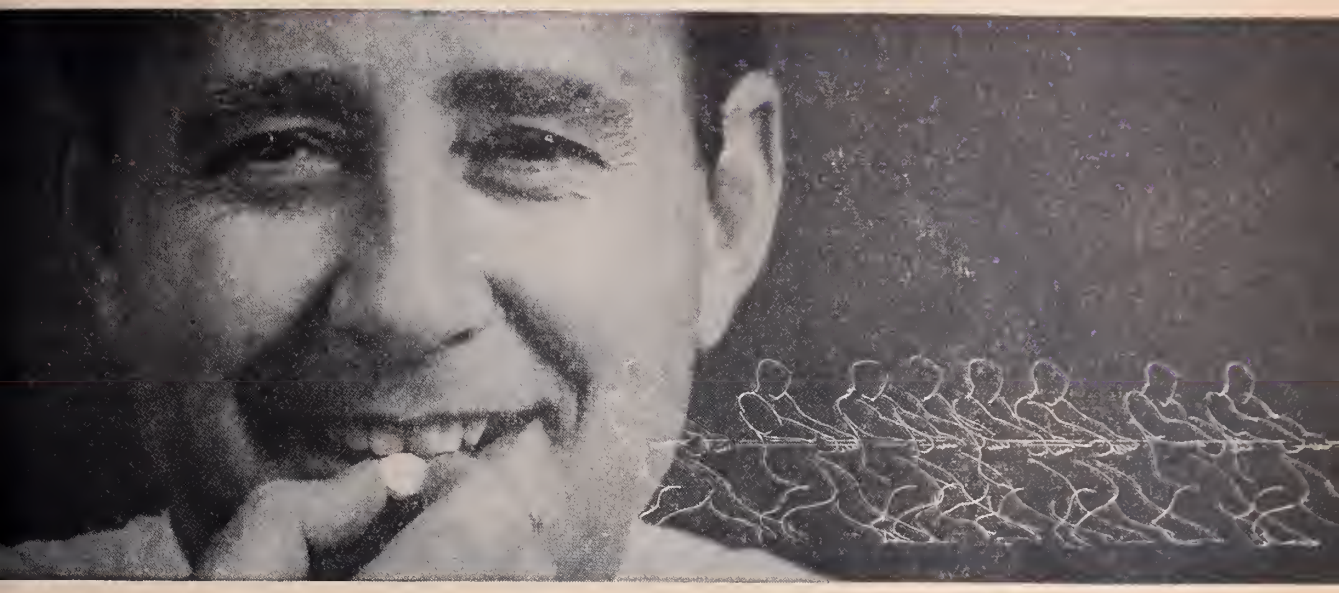
Average adult dose: One teaspoonful after meals and at bedtime. May be habit-forming. Federal law permits oral prescription.

Endo®

Literature on request
ENDO LABORATORIES
Richmond Hill 18, New York

*U.S. Pat. 2,630,400

in antacid therapy...
patient cooperation is half the battle



Are you chancing unsatisfactory results because the patient doesn't like the taste of the antacid you have prescribed? Assure patient cooperation. Prescribe the antacid which assures patient acceptance through its excellent palatability.

'Palatable Margel'

unsurpassed in performance
unequalled in palatability

antacid suspension/tablets

MARGEL is a highly palatable formulation of four antacids: selected aluminum hydroxides, magnesium hydroxide, magnesium trisilicate and calcium carbonate. Balanced to be non-constipating; formulated to be non-chalky. Write for a sample and see for yourself.

Supplied: Margel Suspension — bottles of 12 fluid ounces. Margel Tablets — boxes of 96.
Dosage: SUSPENSION: 1 tablespoonful 20 minutes after meals and on retiring. May be taken with milk if desired. TABLETS: 2 or more tablets 20 minutes after meals and on retiring. May be chewed or allowed to dissolve slowly in the mouth.

MRT *M.R. Thompson, Inc.* CRANFORD, N. J.

STEREO WEBCOR

WEBCOR REGENT CORONET STEREO HI-FI TAPE RECORDER **$329.95**

- Will record and play back both stereo and manaural tapes
- Provides 2-channel and 4-channel stereo playback
- Dual-channel 16-watt amplifier
- Self-contained Stereo system with 2 Hi-Fi Speakers
- 2 directional micraphanes
- In ebany with silver trim

Model 2007

Available at all

DEPT. STORES AND BETTER MUSIC, RECORD, CAMERA AND APPLIANCE DEALERS

Write for catalog to Exclusive N. J. Wholesale Distributors

ALL-STATE DISTRIBUTORS,

INCORPORATED

457 CHANCELLOR AVENUE - WAverly 3-4900 - NEWARK, N. J.

in infectious disease[17,22,30]
in arthritis[18,19,20]
in hepatic disease[2,3,4,5]
in malabsorption syndrome[1,2,6]
in degenerative disease[6,7,19,20]
in cardiac disease[23,28,29,30]
in dermatitis[4]
in peptic ulcer[8,21]
in neuroses & psychiatric disorders[25]
in diabetes mellitus[31,32,33]
in alcoholism[9,11,35,37]
in ulcerative colitis[10,14]
in osteoporosis[13,19]
in pancreatitis
in female climacteric[12]

Patients with chronic disease deserv
the nutritional support provided b

Theragran-M

Squibb Vitamin-Minerals for Thera

11 vitamins, 8 mineral
clinically-formulated and potenc
protected to provid
enough nutritional suppor
to do some goo

with vitamins on

Theragra

also availabl

Theragran Liqui
Theragran Junio

Theragran products do not contain folic aci

1-41 a list of the above references will be supplied on reques

SQUIBB

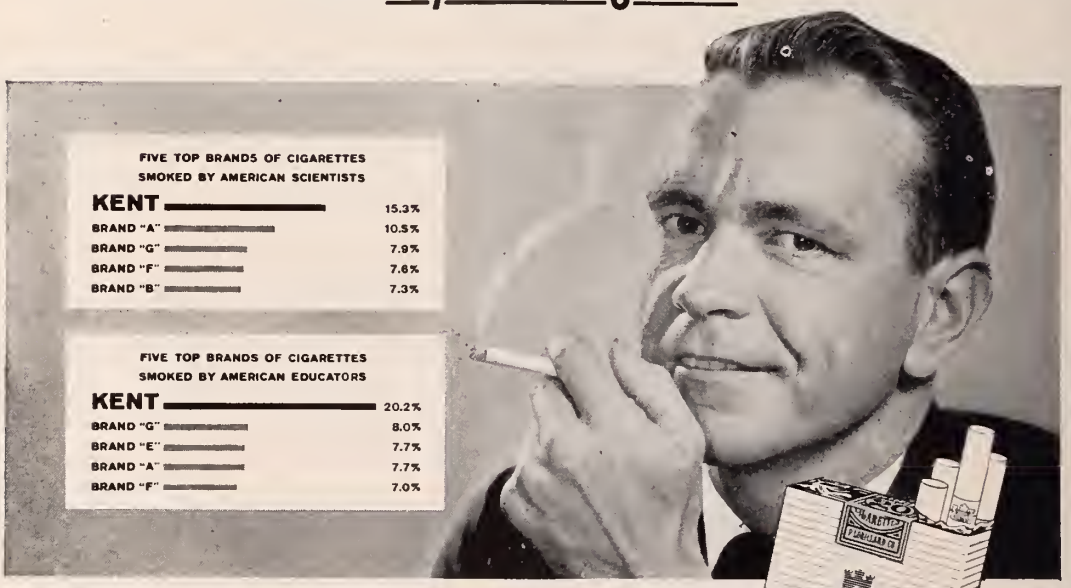
THERAGRAN® IS A SQUIBB TRADEMARK

Squibb Quality—the Priceless Ingredier

ALL OVER AMERICA!

KENT with the MICRONITE FILTER IS SMOKED BY MORE SCIENTISTS and EDUCATORS

than any other cigarette!*



THIS does not constitute a professional endorsement of Kent. But these men, like millions of other Kent smokers, smoke for pleasure, and choose their cigarette accordingly.

The rich pleasure of smoking Kent comes from the flavor of the world's finest natural tobaccos, and the free and easy draw of Kent's famous Micronite Filter.

KING-SIZE, REGULAR SIZE OR CRUSH-PROOF BOX

If you would like the booklet, "The Story of Kent", for your own use, write to: P. Lorillard Company—Research Department, 200 East 42nd Street, New York 17, New York.

For good smoking taste, it makes good sense to smoke KENT

* Results of a continuing study of cigarette preferences, conducted by O'Brien Sherwood Associates, N.Y., N.Y.

A PRODUCT OF P. LORILLARD COMPANY FIRST WITH THE FINEST CIGARETTES THROUGH LORILLARD RESEARCH

© 1960, P. LORILLARD CO.

"I'm sending this urine specimen from the patient with pyelitis to the lab. What'll I order while I'm waiting for the findings?"

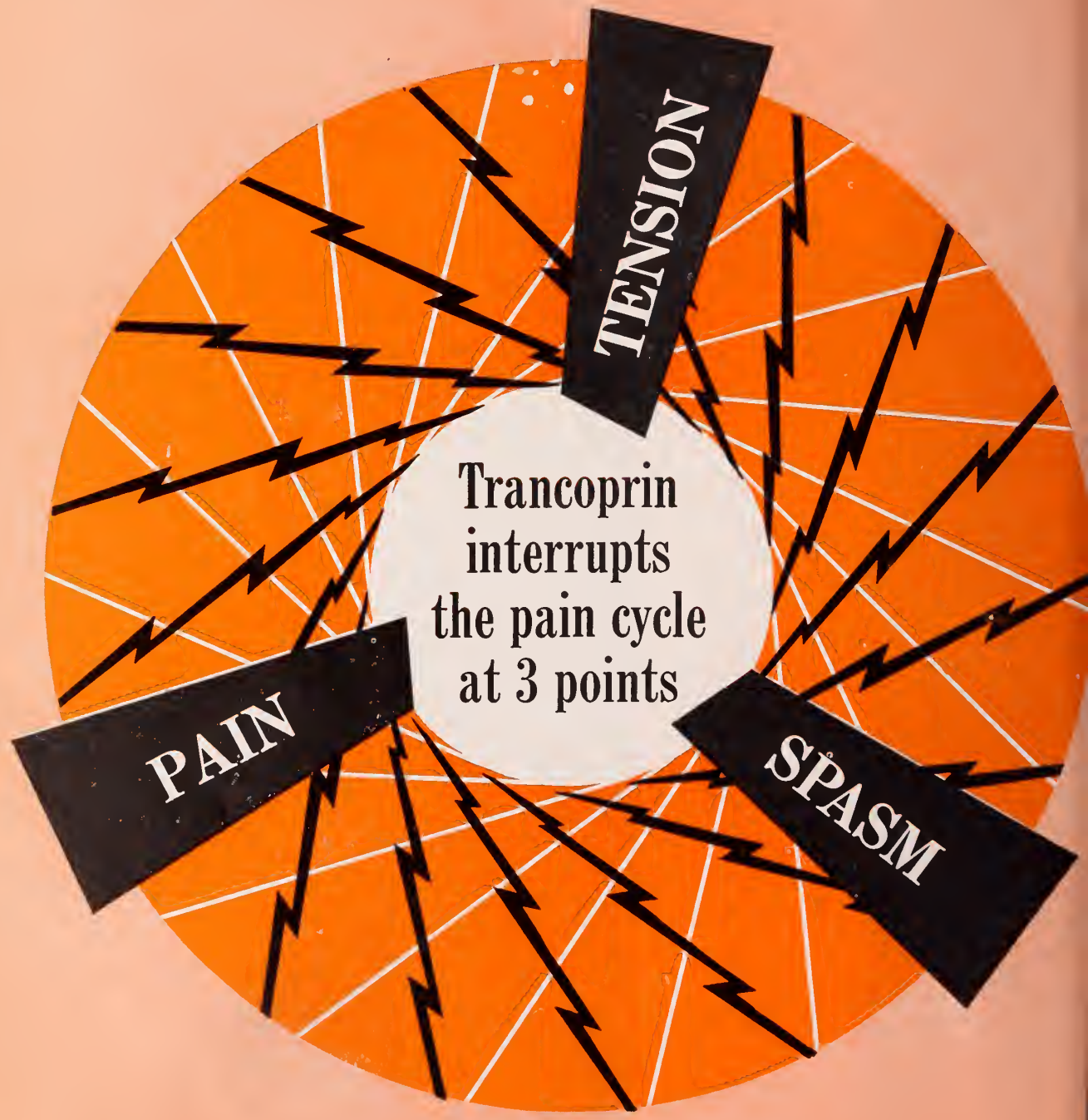
"I'd use AZOTREX. The azo dye will give her quick symptomatic relief. The sulfa-tetracycline combination is likely to hit the common urinary pathogens. If she doesn't respond, then switch to something else when you get the sensitivity data."

announcing...

Trancoprin®

acetylsalicylic acid (300 mg.) and chlormezanone (50 mg.)

Tablets



a broad spectrum non-narcotic analgesic

Trancoprin, a new analgesic, not only raises the pain perception threshold but, through its chlormezanone component, also relaxes skeletal muscle spasm[1-6] and quiets the psyche.[2,3-5,7]

The effectiveness of Trancoprin has been demonstrated clinically[8] in a number of patients with a wide variety of painful disorders ranging from headache, dysmenorrhea and lumbago to arthritis and sciatica. In a series of 862 patients,[8] Trancoprin brought excellent or good relief of pain to 88 per cent of the group. In another series,[9] Trancoprin was administered in an industrial dispensary to 61 patients with headache, bursitis, neuritis or arthritis. The excellent results obtained prompted the prediction that Trancoprin "... will prove a valuable and safe drug for the industrial physician."[9]

Exceptionally Safe

No serious side effects have been encountered with Trancoprin. Of 923 patients treated with Trancoprin, only 22 (2.4 per cent) experienced any side effects.[8,9] In every instance, these reactions, which included temporary gastric distress, weakness or sedation, were mild and easily reversed.

Indications

Trancoprin is recommended for more comprehensive control of the pain complex (pain → tension → spasm) in those disorders in which tension and spasm are complicating factors, such as: headaches, including tension headaches / premenstrual tension and dysmenorrhea / low back pain, sciatica, lumbago / musculoskeletal pain associated with strains or sprains, myositis, fibrositis, bursitis, trauma, disc syndrome and myalgia / arthritis (rheumatoid or hypertrophic) / torticollis / neuralgia.

Dosage

The usual adult dosage is 2 Trancoprin tablets three or four times daily. The dosage for children from 5 to 12 years of age is 1 tablet three or four times daily. Trancoprin is so well tolerated that it may be taken on an empty stomach for quickest effect. The relief of symptoms is apparent in from fifteen to thirty minutes after administration and may last up to six hours or longer.

How Supplied

Each Trancoprin tablet contains 300 mg. (5 grains) of acetylsalicylic acid and 50 mg. of chlormezanone [Trancopal® brand]. Bottles of 100 and 1000.

Trancoprin Tablets / non-narcotic analgesic

References: 1. DeNyse, D. L.: *M. Times* 87:1512, Nov., 1959. 2. Ganz, S. E.: *J. Indiana M. A.* 52:1134, July, 1959. 3. Gruenberg, Friedrich: *Current Therap. Res.* 2:1, Jan., 1960. 4. Kearney, R. D.: *Current Therap. Res.* 2:127, April, 1960. 5. Lichtman, A. L.: *Kentucky Acad. Gen. Pract. J.* 4:28, Oct., 1958. 6. Mullin, W. G., and Epifano, Leonard: *Am. Pract. & Digest Treat.* 10:1743, Oct., 1959. 7. Shanaphy, J. F.: *Current Therap. Res.* 1:59, Oct., 1959. 8. Collective Study, Department of Medical Research, Winthrop Laboratories. 9. Hergesheimer, L. H.: An evaluation of a muscle relaxant (Trancopal) alone and with aspirin (Trancoprin) in an industrial medical practice, to be submitted.

Winthrop LABORATORIES, New York 18, N. Y.

Trancoprin and Trancopal (brand of chlormezanone) trademarks reg. U. S. Pat. Off.

1518M

In over five years

Proven
in more than 750 published clinical studies

Effective
for relief of anxiety and tension

Outstandingly Safe

1 simple dosage schedule produces rapid, reliable tranquilization without unpredictable excitation

2 no cumulative effects, thus no need for difficult dosage readjustments

3 does not produce ataxia, change in appetite or libido

4 does not produce depression, Parkinson-like symptoms, jaundice or agranulocytosis

5 does not impair mental efficiency or normal behavior

Miltown®

meprobamate (Wallace)

Usual dosage: One or two 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar coated tablets.
Also as MIPROTABS® — 400 mg. *unmarked*, coated tablets; and as MEPROSPAN® — 400 mg. and 200 mg. *continuous release* capsules.

WALLACE LABORATORIES / *Cranbury, N. J.*

EM-2537

©TRADE-MARK

# of clinical use...

...for the tense and nervous patient

Despite the introduction in recent years of "new and different" tranquilizers, Miltown continues, quietly and steadfastly, to gain in acceptance. Meprobamate (Miltown) is prescribed by the medical profession more than any other tranquilizer in the world.

The reasons are not hard to find. Miltown is a ***known*** drug. Its few side effects have been fully reported. ***There are no surprises in store for either the patient or the physician.***

CM-2460

NEW analgesic

Kills pain

stops tension

For neuralgias, dysmenorrhea, upper respiratory distress, postsurgical conditions... new compound kills pain, stops tension, reduces fever—gives more complete relief than other analgesics.

Soma Compound is an entirely new, totally different analgesic combination that contains three drugs. First, Soma: a new type of analgesic that has proved to be highly effective in relieving both pain and tension.* Second, phenacetin: a "standard" analgesic and antipyretic. Third, caffeine: a safe, mild stimulant for elevation of mood. As a result, the patient gets more complete relief than he does with other analgesics.

Soma Compound is nonnarcotic and nonaddicting. It reduces pain perception without impairing the natural defense reflexes.*

NEW NONNARCOTIC ANALGESIC

soma® Compound

Composition: Soma (carisoprodol), 200 mg.; phenacetin, 160 mg.; caffeine, 32 mg.
Dosage: 1 or 2 tablets q.i.d.
Supplied: Bottles of 50 apricot-colored, scored tablets.

NEW FOR MORE SEVERE PAIN

soma® Compound + codeine

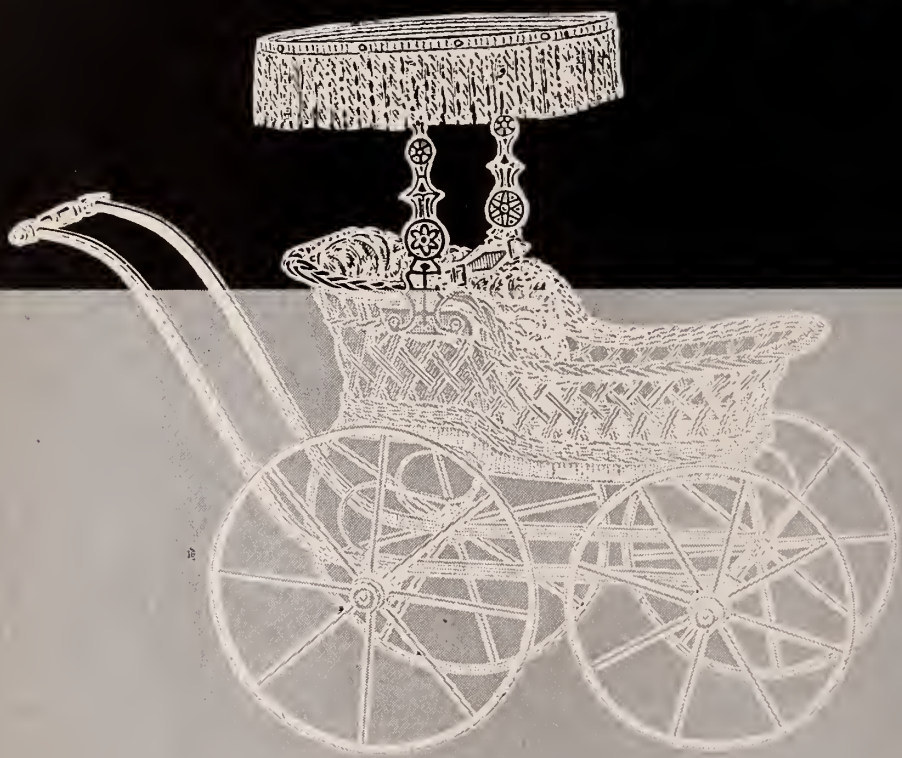
BOOSTS THE EFFECTIVENESS OF CODEINE: Soma Compound boosts the effectiveness of codeine. Therefore, only ¼ grain of codeine phosphate is supplied to relieve the more severe pain that usually requires ½ grain.

Composition: Same as Soma Compound plus ¼ grain codeine phosphate.
Dosage: 1 or 2 tablets q.i.d.
Supplied: Bottles of 50 white, lozenge-shaped tablets; subject to Federal Narcotics Regulations.

**References available on request.*

WALLACE LABORATORIES • Cranbury, N. J.

misca



A "localized capillary syndrome, associated with hemorrhage... actually serves to signal the threat of abortion."[1]

Correction of abnormal capillary fragility "decreases the possibility of retroplacental hemorrhage, or enhances the efficacy of established therapeutic regimes."[4]

C.V.P. helps to diminish abnormal capillary permeability, fragility and hemorrhage by acting to maintain and restore the integrity of placental capillaries.

	Each **C.V.P.** capsule* provides:	Each **duo-C.V.** capsul provide
Citrus Bioflavonoid Compound	100 mg.	200 mg
Ascorbic Acid (vitamin C)	100 mg.	200 mg
	Bottles of 100, 500, 1000	Bottles 50, 100 500, 10

*also in each 5 cc. of syrup (approx. 1 teasponful); Bottles of 4 oz., 16 oz. and gallon.

references: 1. Taylor, F. A.: West. J. Surg., Obstet. & Gynec 64:280, 1956. 2. Ainslie, W. H.: Obstet. & Gynec. 13:185, 1959 3. Pearse, H. A., and Trisler, J. D.: Clin. Med. 4:1081, 1957 4. Greenblatt, H. B.: Obstet. & Gynec. 2:530, 1953.

rriage...

or carriage?

in threatened or habitual aborters
...3 out of every 4 given CVP or duo-CVP
had live healthy babies[1,2,3]

CVP®

the exclusive water-soluble citrus bioflavonoid compound with ascorbic acid

Samples and literature from

u. s. vitamin & pharmaceutical corporation
Arlington-Funk Laboratories, division
250 East 43rd Street, New York 17, New York

"...extraordinarily effective diuretic..."[1]

Efficacy and expanding clinical use are making Naturetin the diuretic of choice in edema and hypertension. It maintains a favorable urinary sodium-potassium excretion ratio, retains a balanced electrolyte pattern, and causes a relatively small increase in the urinary pH.[2] More potent than other diuretics, Naturetin usually provides 18-hour diuretic action with just a single 5 mg. tablet per day — economical, once-a-day dosage for the patient. Naturetin c̄ K — for added protection in those special conditions predisposing to hypokalemia and for patients on long-term therapy.

Supplied: Naturetin Tablets, 5 mg., scored, and 2.5 mg. Naturetin c̄ K (5 c̄ 500) Tablets, capsule-shaped, containing 5 mg. benzydroflumethiazide and 500 mg. potassium chloride. Naturetin c̄ K (2.5 c̄ 500) Tablets, capsule-shaped, containing 2.5 mg. benzydroflumethiazide and 500 mg. potassium chloride. For complete information consult package circular or write Professional Service Dept., Squibb, 745 Fifth Avenue, New York 22, N. Y.

References: 1. David, N. A.; Porter, G. A., and Gray, R. H.: Monographs on Therapy 5:60 (Feb.) 1960. 2. Ford, R. V.: Current Therap. Res. 2:92 (Mar.) 1960.

Naturetin Squibb Benzydroflumethiazide

Naturetin c̄ K Squibb Benzydroflumethiazide with Potassium Chloride

SQUIBB

"NATURETIN" & c̄ IS A SQUIBB TRADEMARK.

What's she doing that's of medical interest?

She's drinking a glass of pure Florida orange juice. And that's important to her physician for several reasons.

How your patients obtain their vitamins or any of the other nutrients found in citrus fruits is of great medical interest — considering the fact there are so many wrong ways of doing it, so many substitutes and imitations for the real thing.

Actually, there's no better way for this young lady to obtain her vitamin C than by doing just what she is doing, for there's no better source than oranges and grapefruit ripened in the Florida sunshine. There's no substitute for the result of nature's own mysterious chemistry, flourishing in the warmth of this luxurious peninsula.

An obvious truth, you might say, but not so obvious to the parents of many teen-agers.

We know that a tall glass of orange juice is just about the best thing they can reach for when they raid the refrigerator. We also know that if you encourage this refreshing and healthful habit, you'll be helping patients to the finest between-meals drink there is.

Nothing has ever matched the quality of Florida citrus — watched over as it is by a State Commission that enforces the world's highest standards for quality in fresh, frozen, canned or cartoned citrus fruits and juices.

That's why the young lady's activities are of medical interest.

© Florida Citrus Commission, Lakeland, Florida

Acts within minutes—KOAGAMIN, unlike other hemostatic agents, acts *quickly* in *minimal* dosages. Working on the late phases of the clotting mechanism, KOAGAMIN does not require massive and prolonged pre- or postoperative dosages to control capillary and venous bleeding.

Acts with predictable safety—In 20 years of clinical use, no toxic or side actions have been reported with KOAGAMIN. Bleeding is arrested without danger of thrombosis, and because KOAGAMIN contains no protein or alkaloid, it can be administered without danger of sensitization or untoward reactions.

Acts effectively in a broad range of indications—Because of its *unparalleled safety* and *outstanding effectiveness,* KOAGAMIN has been successfully employed in...hemorrhagic diseases, abnormal bleeding, blood disorders, surgical cases and trauma.

KOAGAMIN, an aqueous solution of oxalic (5 mg. per cc.) and malonic (2.5 mg. per cc.) acids for parenteral use, is supplied in 10-cc. diaphragm-stoppered vials.

CHATHAM PHARMACEUTICALS, INC · NEWARK 2, NEW JERSEY
Distributed in Canada by Austin Laboratories, Limited, Guelph, Ontario

Chatham

BEFORE, DURING AND AFTER SURGERY

KOAGAMIN®

(parenteral hemostat)

controls bleeding with minimal dosage and maximum safety

10360

NEW PROFESSIONAL LIABILITY INSURANCE PROGRAM APPROVED BY YOUR MEDICAL SOCIETY

American Mutual has been appointed by the 1960 House of Delegates of The Medical Society of New Jersey to provide your professional liability insurance. (See article in August JOURNAL, page 497.)

This means protection by the *first* American liability insurance company. Long experience in the field of professional liability insurance has led to a practical solution of one of the important problems—that of *loss control*—faced by the medical profession.

Insurance for Professional Liability and Professional Premises Liability is available to members of The Medical Society of New Jersey. Professional Liability Insurance is also available to the registered nurses and qualified technicians employed by our policyholder doctors.

Protection for Libel, Slander and Defamation of Character arising out of activities on committees of State and County Medical Societies and committees of licensed hospitals is furnished to all insured doctors.

Please address your request for further information about this program to:

American Mutual Liability Insurance Company

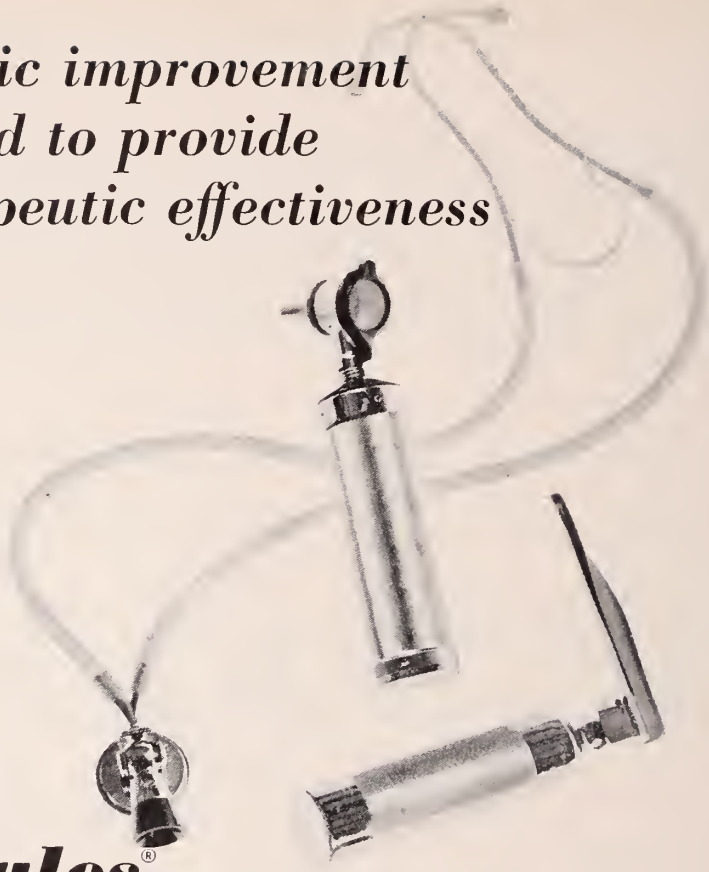
PROFESSIONAL LIABILITY DEPARTMENT

68 SOUTH HARRISON STREET EAST ORANGE, NEW JERSEY

JOSEPH A. BRITTON, Manager ORANGE 3-2575

HOME OFFICE: WAKEFIELD, MASS.

an antibiotic improvement designed to provide greater therapeutic effectiveness



now Pulvules® Ilosone®

(propionyl erythromycin ester lauryl sulfate, Lilly)

in a more acid-stable form assure adequate absorption even when taken with food

Ilosone retains 97.3 percent of its antibacterial activity after exposure to gastric juice (*p*H 1.1) for forty minutes.[1] This means there is more antibiotic available for absorption—greater therapeutic activity. Clinically, too, Ilosone has been shown[2,3] to be decisively effective in a wide variety of bacterial infections—with a reassuring record of safety.[4]

Usual dosage for adults and for children over fifty pounds is 250 mg. every six hours.
Supplied in 125 and 250-mg. Pulvules and in suspension and drops.

1. Stephens, V. C., *et al.*: J. Am. Pharm. A. (Scient. Ed.), *48*:620, 1959.
2. Salitsky, S., *et al.*: Antibiotics Annual, p. 893, 1959-1960.
3. Reichelderfer, T. E., *et al.*: Antibiotics Annual, p. 899, 1959-1960.
4. Kuder, H. V.: Clin. Pharmacol. & Therap., in press.

Lilly
QUALITY · RESEARCH / INTEGRITY

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U.S.A.

032644

THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

Edward Zeh Hawkes, 1865-1960

New Jersey medicine will somehow not seem the same without the sage voice, the sterling precept and the gracious presence of E. Zeh Hawkes. For here was the mold for the ideal doctor. He was a sensitive and skilled practitioner; a citizen of vision and social conscience; a leader in organizational work, and a leader in medical practice; and withal, he was a good sport, and—in the truest meaning of that phrase: a gentleman and a scholar.

Are these but the formal words of eulogy that one always gives to a senior colleague? No—they are simple listings of a number of truths. He was, it has been said, a citizen of vision and social conscience. It was Dr. Hawkes who spear-headed the Emergency Relief medical plan in Newark during the depression: a plan that then served as a model for dozens of other cities. To call him a leader is to repeat the obvious. He was president of the Essex County Medical Society (1914); of the Academy of Medicine (1928); and of The Medical Society of New Jersey (1939). He was a founder and an early secretary of the American Surgeons' Club—forerunner of the American College of Surgeons. He was also a founder, and the first medical director of the Newark Presbyterian Hospital. He was one of the select group who established the American Board of Surgery (1937).

A pioneer in medical practice! That is often said loosely of any doctor who has managed to live beyond the age of 70. But E. Zeh Hawkes was a pioneer in fact and not just by courtesy. He administered a spinal anesthesia

PUBLISHED MONTHLY SINCE 1904
Under the direction of the Committee on Publication
FRED B. ROGERS, M.D., *Chairman*

HENRY A. DAVIDSON, M.D., *Editor*
MIRIAM N. ARMSTRONG, *Assistant Editor*

Place of Publication, Printing and Mailing—116 Lincoln Avenue, Orange, N. J.
Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.
Send all communications for publication to P.O. Box 904, Trenton 5, N. J. — Telephone EXport 4-3154
Each paying member of the State Society is entitled to receive a copy of THE JOURNAL every month
Whole Number of Issues 675

VOL. 57, NO. 11 NOVEMBER, 1960 Subscriptions, $3.00 per Year Single Copies, 30 Cents

as early as 1902—certainly the first such procedure done in New Jersey. Together with Edward Sprague, he gave the first blood transfusion in this state—in 1908. (And that was without benefit of blood typing). He was probably the first doctor in New Jersey to be trained in pathology. In 1898-1899 he worked with William Welch at Johns Hopkins. When Newark City Hospital moved to its then new and resplendent Fairmount Avenue building in 1901, Dr. Hawkes was invited to establish the laboratory of pathology there. (Hardly anybody else could use a microscope then).

A good sport? His golf score never got much higher than his age—so he was doing the course in the 80s when he was in his 80s. (He won several national championships too). Tennis didn't tire him until he was almost 60.

Today we bemoan our public "image." Why, we ask ourselves, does the public seem to misunderstand our motives? And our advisers keep telling us to take more active part in public affairs; to assume leadership in medical-social matters; to remain true to the traditions of a patient-centered practice; to be bold enough to keep in pace with medical progress; to grow, to move, to participate fully in the main-stream of community life. E. Zeh Hawkes did not need such advice. He lived it.

We have many models today. We can imitate the doctor with the two air-conditioned, big-powered cars. Or the one who isolates himself from everything and everyone outside his practice. We doctors come in all sizes, shapes and philosophies. But to fashion a guide for a young medical practitioner today, we can do no better than to point to E. Zeh Hawkes and say: "Son—never mind the air-conditioned cars. There's your model. Shape yourself like him—if you can."

He has left big foot-prints in the sands of time. He has made us all proud of the title: "doctor."

Civic Service by M.D.s

The admonition to physicians to take active part in civic affairs is not a new one. A recent survey lends support to the thesis that physicians in many communities are not contributing enough effort and time to civic affairs. Thus, Mr. John H. Biddle, publisher of the Huntington (Penna.) *Daily News,* recently asked 100 publishers, editors, and writers for their views on the doctor's civic role. As Biddle recently reported in *Philadelphia Medicine,* many feel that doctors are letting their communities down.

How do you convince the public that the medical profession is *not* made up of selfish men? One editor wrote: "One of the best ways . . . is to shoulder some of the responsibility which falls on the physician—not as a medical man, but as an intelligent member of the community."

A Pennsylvania editor added, "a physician has more responsibility in civic matters . . . than the ordinary run of individuals."

Said another editor: "So long as the doctor in general refuses to fight for fear of getting his 'hands dirty' or for fear of upsetting the status he now enjoys, the American medical scene will undergo some vast changes."

An Iowa mayor wrote: "All members of my administration felt a sense of responsibility except the doctor who served on the board of health . . . The medical profession is filled with fine people, who get the idea that in being a doctor they are discharging their entire debt to society . . .

"The doctor has lost his favorable image in the eyes of the people . . . I think it is to a very great extent due to the failure of (doctors) to take off their coats and go to work doing the community jobs that every good citizen should do."

And a New England publisher bluntly said: "After years of association with the physicians of this community as a trustee and, latterly, president of the local hospital, I witnessed so much evasion of civic responsibility on the part of the professional group that I severed my connection with the institution . . .

"Professional people are rare in the active membership of service clubs, chambers of commerce, and other organizations which make the community a better place in which to live . . . Manifestation of civic responsibility by doctors has been lacking."

The indictment may seem a bit harsh, but it reflects the views of an important, civic-minded segment of the community. Our own leaders in New Jersey medicine have, for the most part, shown commendable interest in civic activities. Our current President, Dr. McCall, was president of the Newton Rotary Club, and his predecessor, Dr. Bowers, had been mayor of Mendham. Dr. Gardner has long been one of the valuable citizens of Essex County as well as a leader in fraternal affairs. In 1957, Dr. Kump was named "Citizen of the Year" in Cumberland County—an award that previously had always gone to a project not to an individual. Dr. Fritts was president of his community's Rotary Club. One of our Fellows was a Freeholder. The list could be extended indefinitely so far as our top Medical Society officials are concerned.

In an earlier era, doctors were even more active in civic affairs. In 1857, Dr. William A. Newell, a Monmouth County physician, was elected Governor of New Jersey. Indeed, a glance through Dr. Rogers' unique book* on the subject tells us something of the keen civic interests of the doctors who make up our professional and spiritual heritage. And even today, our own organizational leaders come largely from the ranks of community leaders.

However, the devoted labors of our officials cannot excuse the rest of us from the exercise of civic duty. Doctors are busy; and as has been said: "If you want a job done, give it to a busy man."

*Rogers, F. B.: Help Bringers: Versatile Physicians of New Jersey. New York, 1960. Vantage Press.

Christmas Seals and the Hidden Invader

No blazing temperature heralds its attack; no sudden agony; no dramatic collapse. Silently the bacterium invades the body. It waits for the slightest lowering of resistance: fatigue, another infection, inadequate food, stress. It then bursts into life.

Christmas Seal dollars are supporting research for blood studies which, hopefully, will make it possible to diagnose tuberculosis swiftly. Until such a test is found, however, our only defense against the disease is to protect the health of everybody, everywhere, to reduce the chances of infection, and to redouble tuberculin testing and chest x-raying efforts so that everyone who needs treatment can get it before the disease has gone too far.

Educating people to protect themselves against tuberculosis costs money. Also expensive are funds for tuberculin tests in schools and the offering of chest x-ray surveys.

The once-a-year Christmas Seal campaign is the only way tuberculosis associations have to get funds. All people should support the program and we doctors should be able to tell them why.

Original Articles • • •

MAX FINKELSTEIN, M.D.

Jersey City

Cigarette Smoking and Lung Cancer

A Review and an Appraisal

It is hard to believe what we don't want to believe. In this sober indictment, Dr. Finkelstein presents a strong case for the relationship between smoking and lung cancer. It does seem as if fear of smoking would save lives.

DURING the past 30 years, the incidence of and death rates from primary carcinoma of the lung have shown a remarkable increase. The statistics on the subject are unequivocal. This tumor now causes more deaths in males than any other neoplasm.[1] In 1930 there were only 3,000 deaths from this cause in the whole country. In 1953 the number was 23,000. In 1957, there were 26,000 such deaths among males, and 4,500 among females.[2] In California,[3] the rate for men sky-rocketed in ten years from 9.7 to 30.1. In women it rose from 3.3 to 5.1. In Massachusetts,[4] the rate per 100,000 was 3. in 1930, and 42. in 1955.

Similar reports have come from all over the world. The rate in Switzerland[4] increased 32 times between 1900 and 1952. In England,[5] deaths rose from 612 in 1922 to 9,287 in 1947. The 1901 to 1920 rate was 1.1 for males and 0.7 for females; the 1936-1939 rate, 10.6 for males and 2.5 for females. In Liverpool,[6] in 1950, carcinoma of the lung was the commonest visceral cancer in men, having increased from 8 per cent of all male malignancies in 1944 to 12.2 per cent in 1949.

Part of this frightening increase is due to better diagnosis, but this represents only a small fraction of the total. The increase has been universal, has affected both urban and rural areas. It is noted in medically backward countries as well as in medically advanced nations. There has been an increased incidence in necropsy material, corresponding closely to the incidence clinically. The increase in males has been much greater than in females, though both sexes must have benefited equally by improved diagnostic methods.

NOXIOUS inhalants have long been accepted as a probable cause of pulmonary malignancy. Bronchial carcinoma has been known to occur frequently among miners of cobalt, nickel and uranium, and among workers handling chromates and arsenic. More recently, increased incidence has been found in men working in gas manufacturing plants in England. In 1912, Adler,[7] suggested that tobacco smoke might play a role in the etiology of this disease. The first formal study of this problem was done by Muller,[8] who found only 3 non-smokers among 86 cases of cancer of the lung, and 56 heavy smokers in this group. In 1941, Ochsner and De Bakey[9] demonstrated that the curve of incidence of cancer of the lung parallels that of cigarette sales. This correspondence[12] has been observed repeatedly in a number of countries.[14]

Modern studies of this problem may be subdivided into statistical, pathological and laboratory investigations. The first have followed two methods: the retrospective and the prospective. In general terms, the former involved the investigation of known cases of bronchial carcinoma in respect to smoking habits; the latter, continuous study of large groups of individuals whose smoking habits were known, with the view of determining how often lung cancer develops in the categories of non-smokers and smokers over a period of years.

STATISTICAL STUDIES

Among the retrospective studies, Wynder and Graham [10] studied 684 cases of proved bronchogenic carcinoma. Their series included 605 males and 25 females with epidermoid or undifferentiated carcinoma. A group of general hospital patients was used as a control. It was found that 96.5 per cent of the males with bronchogenic carcinoma of this type were moderate to heavy smokers, compared to 73.7 per cent in the control group. Excessive smokers constituted 51 per cent of the lung cancer group, but only 19 per cent of the control group. Furthermore, only 1.3 per cent of those with lung cancer were non-smokers; while 14.6 per cent of the controls had never smoked. In the lung cancer group, 96 per cent had smoked for over 20 years, and 94 per cent smoked cigarettes. It was concluded that excessive and prolonged use of tobacco was a factor in the development of bronchogenic carcinoma, and that the figures, as given, were of a very high order of statistical validity.

Levin, Goldstein and Gerhardt[11] studied 1,045 cases of lung cancer, compared to 605 non-cancer patients as a control. They found that there were more smokers among the cancer patients than among the controls, due to an increased proportion of cigarette smokers among those with primary cancer of the lung, and of pipe smokers with carcinoma of the lip. Once again, statistical analysis revealed very high significance in the figures given.

Doll and Hill[12] gave a detailed questionnaire on smoking habits to 1,732 cases of cancer and 743 general medical and surgical cases. Repetition of this after 6 months, to a group of 50 of these individuals, revealed practically the same answers, a finding strongly confirming the accuracy of the information elicited. Among 649 cases of lung cancer in males, 2 or 0.3 per cent, were non-smokers, compared to 27 or 4.2 per cent in the non-cancer group; among females, there were 19 non-smokers, or 32 per cent, compared to 53.3 per cent in the control group. There was no mention in this study of the histological type of neoplasm. Twenty-six per cent of the males with lung cancer were heavy smokers, compared to 13.5 per cent of the controls.

In a continuation of this study, these authors [13] questioned and compared 2,710 cases of cancer (including lung, stomach and large bowel) and 1,632 controls, matched as to age, place of interview, social class, place of residence, and sex. There were 1,465 cases of lung cancer in this study. When compared to their controls, no association was found between lung cancer and social class, occupation or exposure to fumes in home or residential environment. Of the 1,357 male patients with primary lung cancer, 0.5 per cent were non-smokers, compared to 4.5 per cent of the controls. Of the men with lung cancer, 25 per cent were heavy smokers, while only 13 per cent of the controls were in this category. Among the 108 women with lung cancer 37 per cent were non-smokers, compared to 55 per cent of the controls and 11 per cent were heavy smokers compared to 0.9 per cent among the controls. The authors found that among male non-smokers, aged 45 to 64, lung cancer as a cause of death was negligible; among heavy smokers the rate was 3 to 5 per thousand living, yearly.

Wynder [14] studied 729 cases of bronchial carcinoma for previous lung disease, city residence, occupation, and use of tobacco. These were divided into three groups, each interviewed in a different manner. As control, a

general hospital population was used. No relationship was found between lung cancer and pre-existing tuberculosis or previous influenza; relationship to city residence was present in two of the three groups, not in the other; and a possible association was seen to some occupations involving exposure to fumes. The three groups agreed closely, however, as to the apparent influence of smoking. Among 650 males with epidermoid or undifferentiated lung cancer, non-smokers comprised 1.5 per cent whereas there were 15 per cent among the controls; among 25 females so afflicted, there were 40 per cent non-smokers compared to 86 per cent among the controls.

The author concludes that epidermoid or undifferentiated carcinoma rarely occurs in a man who has not smoked moderately or heavily for many years.

Hammond and Horn [15] found the death rate from proved lung cancer, excluding adenocarcinoma, in men, to be 9. for non-smokers, 31. for moderately heavy and 94. for heavy or excessive smokers. In another study, these authors [16] found that among 448 deaths from lung cancer, 15 were in non-smokers and 8 among occasional smokers. There were 397 deaths due to carcinoma of the lung among cigarette smokers, compared to 37 expected deaths. The death rate increased rapidly with the amount smoked, from 8. in those smoking less than a half pack daily, to 23. for those smoking over a pack each day. Excluding adenocarcinoma, only 4 deaths occurred in non-smokers. The rate was lower for those who had stopped smoking over a year. The effect of urban residence was very small compared to that of smoking. Rates were higher among smokers in all areas, from large city to country.

Lombard and Snegireff [17] studied 500 men with lung cancer, and compared them with seven control groups, each selected by different criteria (volunteers, hospital residents, random urban residents, rural residents, and others) and found strong association only with cigarette smoking. Non-smokers had a rate of 6., light smokers 21., moderate smokers 75., and heavy smokers 220. Measurable personality variables, irritants, occupation and heredity showed no association with lung cancer.

POSSIBLE FALLACIES

THESE and other smaller studies, all indicate the same thing—that cigarette smoking bears a close relationship to the development of epidermoid and undifferentiated bronchial carcinoma, especially in men. The figures seem to be conclusive, but criticism arose on the basis that since all conclusions depend on the accuracy of the smoking history, and that this was always obtained retrospectively, error and bias could arise, both from failure of the patient or other informant to give accurate information, or on the part of the questioner in eliciting it by leading questions.

Most of the investigators making these reports were well aware of this possibility. Controls were varied and carefully adjusted to be comparable in as many factors as possible. In some of the studies, checks as to the accuracy of the data were made, which seemed to bear out their validity. Doll and Hill [12] found that the smoking habits of those cases misdiagnosed initially as lung cancer, proved to be similar to the control group, rather than to the proved lung cancer group. Levin *et al.*[11] reported similarly, as did Wynder and Graham.[10] In a number of the studies, especially the larger and more carefully organized, experienced statisticians participated actively during the study, and all factors were presumably carefully analyzed for statistical validity and significance. It is difficult to see how better studies of this type could be devised.

LARGE SCALE STUDIES

THE prospective studies were done to eliminate possible errors inseparable from retrospective analysis. Those reported are massive works, involving huge numbers of individuals. Doll and Hill [19] studied the course of 40,700 British doctors who replied to their question-

naire on smoking habits. There were 34,500 men and 6,200 women in this group. At the end of 29 months, there had been 36 deaths from lung cancer in males over 35 years old at the commencement of the study. *None of these deaths occurred among non-smokers.* The rate for all men was 0.66; for light smokers 0.48; for moderate smokers 0.67; and for heavy smokers 1.14. Death rates were considerably lower than in the general population. This was ascribed to the failure of seriously ill individuals to answer the questionnaire. They also noted that, in general, the findings bore out the conclusions of their earlier retrospective studies.

Continuing their study of this group, the same authors [20] reported that after 53 months, there occurred 84 deaths from primary lung cancer, in which the diagnosis was definitely established, in men over the age of 35 at the beginning of the study. One of these deaths was in a non-smoker. The death rate from this cause, for non-smokers, was therefore 0.07. Further analysis revealed the following rates: all men, 0.81; all smokers, 0.9 (13 times non-smokers); light smokers, 0.47 (6 times non-smokers); moderate smokers, 0.86 (12 times non-smokers); and heavy smokers 1.66 (23 times non-smokers). That the rate for all smokers exceeds light smokers, may be due to the large proportion of heavy smokers included. No association was noted between smoking and cancer of other sites, and slight association with other pulmonary disease and coronary thrombosis. The association of smoking and lung cancer was found highly significant; that with all deaths, and the other diseases studied, not significant. It was also found that smokers who gave up cigarettes, showed a lower rate of lung cancer than those who continued to smoke. Those who had stopped 10 years or more had a rate of 0.35; less than 10 years, 0.59; and those still smoking, 1.03; and those men who continued smoking over 25 cigarettes daily, 2.76.

Hammond and Horn [21] studied the course of over 187,000 men, aged 50 to 69, all of whom were apparently in good health when enrolled between January 1, 1952 and May 31, 1952. As of October, 1955, they found the total death rate of all regular cigarette smokers 68 per cent above non-smokers. The rate increased with the amount smoked; for heavy smokers, the rate was 123 per cent above non-smokers. Those who had stopped smoking for over a year at the time of enrollment had a lower rate than those continuing to smoke.

When these rates were analyzed for specific cause of death, it was found that primary cancer of the lung occurred 448 times. Only 15 of these men had never smoked, and eight smoked only occasionally; there were 397 deaths from primary lung cancer in men who had smoked cigarettes regularly. If the rate for smokers had been the same as for non-smokers, there would have been only 37 deaths from this cause. Cancer of the lung, therefore, occurred eleven times as often in smokers as in non-smokers. The increased rate was proportional to the amount smoked. For those smoking less than a half pack daily, it was 8 times; between one half and one pack daily, 10.5; and over a pack daily 23.4. No increase was noted in occasional cigarette smokers or in pipe or cigar smokers.

For lung cancer excluding adenocarcinoma, the following rates were found; non-smokers 3.4; occasional smokers, 11.9; regular cigarette smokers, 78.6. Classified according to amount smoked daily, the rate was 51.4 for men smoking less than a half pack a day; 59.3 if one half to a full pack was the daily amount; and 143.9 for those consuming between 1 and 2 packs daily. Among excessive smokers, who consumed over two packs daily, the rate was 217.3.

Men who had given up smoking for over a year had a lower rate than those who continued smoking, at all levels of cigarette consumption; but the rate remained higher than in non-smokers. Those who continued to smoke less than one pack daily had a rate of 57.6; those who had stopped smoking for between one and ten years, a rate of 35.5; and those who had stopped more than 10 years before, a rate of 8.3, compared to a rate of 3.4 among

non-smokers. Among those who had smoked, or were still smoking, more than one pack daily, the latter had a rate of 157.1; after 1 to 10 years of non-smoking, the rate was 77.6; and those who had not smoked for over 10 years showed a rate of 60.5.

URBANIZATION

Stocks and Campbell [18] studied the lung cancer death rate in men who were residents of three areas differing in urbanization and atmospheric pollution. They found that in rural areas, the death rate increased with the number of cigarettes smoked; that in mixed rural-urban areas, the rates for light and moderate smokers were higher than in purely rural areas, but those of heavy smokers were not essentially different; and that the urban rate was higher than the others, although the rate of increase was not as great as that found with increased smoking. Among heavy smokers, the rural and urban rates were almost comparable after the age of 55. They concluded that an urban factor was additive to the smoking factor in the etiology of lung cancer, but that the *smoking factor was the most important.*

In the Hammond-Horn study,[21] urban smoking rates exceeded the rural rates by 56 to 34; standardized for smoking habits as well as residence, the rates were 52 to 39. However, the effect of smoking was seen in all locations, from the largest cities to rural localities. For non-smokers and for smokers, respectively, the rate for large cities was 14.7 to 85.2; for medium-sized cities 9.3 to 70.9; for small towns 4.7 to 71.7; and for wholly rural areas, zero to 65.2.

Dorn,[22] in a study of 249,000 men who answered a questionnaire on their smoking habits, occupations and place of residence, found that for primary cancer of the lung, the death rate for cigarette smokers, over a period of 2½ years, was 9.35 to 1 for non-smokers; for smokers of cigarettes plus other forms of tobacco 6.4 to 1; for cigar smokers, 1.5 to 1; and pipe smokers, 1.3 to 1. For all smokers, observed deaths were 312; expected deaths 52; and the extra mortality ratio, 6 times.

THEORIES OF PATHOGENESIS

From these studies, both retrospective and prospective, the obvious conclusion is that cigarette smoking is closely related etiologically to the development of epidermoid and undifferentiated bronchial carcinoma among men. No one denies the figures, but a number of statisticians have criticized the studies, as producing unavoidable bias in the selection of individuals to be studied. However, the fact that both prospective and retrospective studies agree, and that studies by various authors, using different populations and various types of investigations and controls, all came to the same conclusions, would seem to present a strong case for the thesis. It is obviously impossible to present mathematically precise evidence in a study of this type, and to eliminate all theoretical weaknesses in the argument. All that can be expected, is proof beyond a reasonable doubt; and that seems to have been provided.

Acceptance of the association of smoking and lung cancer does not require the discovery of the particular chemical or physical agent in tobacco, that actually causes the disease. Such an agent may exist, and be hidden from our knowledge, yet the association may exist nevertheless. Laboratory findings have demonstrated carcinogens in tobacco smoke and the tar condensed from this smoke. Campbell [23] produced pulmonary adenomas in mice by exposure to cigarette smoke, as did Essenberg,[24] Lorenz [25] however, obtained negative results. Leuchtenberger [26] noted increased hyperplasia, metaplasia, and *carcinoma-in-situ*, in mice exposed to cigarette smoke; and Blacklog [27] produced bronchial carcinoma in rats by injecting cigarette smoke condensate and tubercle bacilli. Numerous investigators have produced skin cancers in laboratory animals by applying cig-

arette smoke condensate and tar, among them Wynder and Wright.[28]

Kotin and Falk[29] state that tobacco smoke impairs ciliary action, slows mucus flow, and increases cellular permeability. Particulate matter is thereby retained and given the opportunity to damage the bronchial mucosa. Some investigators have seen changes in the bronchial mucosa of smokers, which they consider precancerous lesions. Auerbach and others[30] studied the tracheobronchial tree of 41 men. They found an increase in basal cell hyperplasia, mucosal stratification, and squamous metaplasia in smokers, the severity of each increasing with the amount reportedly smoked by the subject examined. Continuing and extending this work, these investigators[31] confirmed their earlier findings, and also noted that *carcinoma-in-situ* occurred in six times as as many slides in heavy smokers as in non-smokers, with light smokers in an intermediate position. Reporting in detail, they state that this occurred in a few of the many slides studied, in 5 out of 16 non-smokers (30 per cent); in 12 out of 20 light smokers (60 per cent); 35 out of 47 heavy smokers (74 per cent); and in 26 out of 34 cases of lung cancer (74 per cent), at sites other than the actual position of the cancer. Pathologic changes occurred in more extensive areas of the bronchial tree, in smokers, than in non-smokers.

The entire group, smokers and non-smokers, were exposed to about the same industrial and urban environment.

Chang[32] studied the entire tracheobronchial epithelium of smokers and non-smokers, and found changes in the goblet cells of smokers, with an increase in size and number in some areas, and decrease in other areas, in heavy smokers. Other changes were hyperchromaticism and variation in mitotic figures and nuclei, considered as early metaplasia and precancerous changes, seen in heavy smokers and not in non-smokers. In individuals who had smoked heavily for over 20 years, portions of the trachea and larger bronchi were covered by pseudo-stratified ciliated epithelium, the cilia were shortened, and the average thickness of the epithelium increased. There were increased numbers of atypical basal cells, and metaplasia was more frequent than in non-smokers.

THE GENOTYPE THEORY

MEN are affected much more often than women. Even among heavy smokers, only a minority develop lung cancer. These two facts lead to speculation about the role of heredity and constitutional susceptibility. This, in turn, has produced the hypothesis of a "genotype" susceptible to the development of bronchial carcinoma; and to reconcile this with the evidence implicating smoking, an assumption that this "genotype" is also prone to heavy smoking. The point of this hypothesis is, that such an individual would develop lung cancer even if he did not smoke, and that the tendency to smoke and develop lung cancer simply go together, as, for instance, blond hair and blue eyes.

The evidence for this theory is tenuous. Several papers[33] have been published indicating that homozygous twins tend to be similar in smoking habits, even if reared apart from each other.[34] But there has been no evidence that lung cancer follows any hereditary pattern. Constitution may make some individuals more susceptible to the development of lung cancer, given also exposure to some deleterious factor; but that factor would still be necessary before cancer develops. Nor can any constitutional or hereditary factor account for the recent increase in lung cancer incidence. Some new environmental factor must have been introduced. The alternative is to assume that a new genetic factor arose *de novo* in men all over the world, in the past 30 years, an event that does not appear at all probable. Finally, the observation that, among smokers, those who stop smoking for a period of years show a decreased incidence of bronchial carcinoma,[35] is telling evidence against the existence of this highly specialized "genotype."

CONCLUSION

FROM all available evidence, this conclusion seems inevitable: bronchial carcinoma has increased greatly, due to the activity of some inhaled substance not present in prior years or if present, only in much smaller amounts. The rate of general atmospheric pollution must be considered, and numerous studies have been made on this subject. That the air we breath is being progressively vitiated and polluted is a melancholy fact. That these pollutants contain a number of substances carcinogenic in adequate concentration is unquestioned. A number of writers have ascribed to atmospheric pollution the major part of the rise in lung cancer. But in many of the studies already reviewed, this factor was considered and investigated, and the conclusion [6,13,14,16] drawn that although it may play a role, this is much less important than that of cigarette smoking. This conclusion seems to be valid at this time. One investigator [29] assigns to cigarette smoke an accessory role, and gives a primary inciting role to atmospheric pollutants. The grounds for this belief appear to be inconclusive; and in any case, it matters little except academically.

SUMMARY

IT MAY be stated with a high degree of confidence, that the smoking of cigarettes by men adds very much to the risk of developing bronchial epidermoid and undifferentiated carcinoma. A large number of statistical studies of groups analyzed according to smoking habits and incidence of lung cancer, yields convincing evidence that smoking and this disease are closely related etiologically. These studies are both retrospective and prospective. There are no similar studies showing a negative relationship. Atmospheric pollution is probably a factor in the cause of lung cancer, but its effect is small compared to smoking, except for a few unusual situations. Infections, industrial and other environmental factors, (except sex and age) seem to play no role in this disease. Pathologic studies have shown proliferative, irritative, metaplastic and precancerous changes in the bronchial epithelium of smokers, to a degree and to an extent far in excess of those present in non-smokers. *Carcinoma-in-situ* has also been found frequently in smokers.

It has been estimated [36] that four out of five cases of lung cancer in men from age 25 to 75 are due to smoking. The incidence among heavy smokers [1] has been judged [5] to be from 13 to 50 times that in non-smokers.[37] Hundreds of thousands of men will die of primary lung cancer within the next decade or two, who would not have developed this disease at all, had they not smoked cigarettes. Unless the carcinogen is removed, or a cure for cancer is found, the toll eventually will be fantastic and catastrophic.

115 Kensington Avenue

Bibliography will appear in author's reprints.

Dandruff May Cause Blepharitis

The scales of dandruff can fall into, or be swept into the eyes causing blepharitis. So reports J. S. Jordan of the Pennsylvania Academy of Ophthalmology in a study published in the May 1959 *Pennsylvania Medical Journal.* The cure? Simple. Shampoo the hair twice a week—if this seems frequent, Dr. Jordan says it is the one way to stop the blepharitis. The author has no preference as to the type of shampoo.

BENJAMIN B. BURRILL, M.D.

Montclair

Recent Advances in Dermatology*

New drugs are being poured out at about one a day. Many are valuable in dermatology and Dr. Burrill here gives us a road map through the newer dermatologic drug list.

WE PHYSICIANS are faced with the necessity of evaluating and learning to use a constantly changing array of new drug products. There are some 300 of these developed each year. Many are specifically designed for dermatologic use while others are eventually found to have some dermatologic application. These new drugs have revolutionized the practice of dermatology during the post-war years and during the past decade in particular.

This change is seen also in the nature of the skin diseases that we treat. Today contact dermatitis of one kind or another ranks first among the most common dermatoses. Thirty years ago it was ringworm which now ranks sixth. Acne remains in second place where it was then. Scabies and impetigo, once common, are no longer included among the first ten. Nevi have assumed increasing importance as public awareness is stimulated by extensive publicity. Patients are more likely to seek medical advice about them now than formerly. X-ray and radium are being used less frequently while grenz radiation seems to take over some of their function. One of our dermatology professors made the remark that "sometime around the year 2,000, some bright young dermatologist would discover that x-ray was an excellent treatment for acne."

Competition among the pharmaceutical houses is responsible for great improvement in the elegance of topical medication. This is especially true of acne medicaments where elegance is of prime importance. Most dermatologists prefer to write their own prescriptions in the belief that they can best suit the individual's situation in that way. The proprietaries do have a definite place, however, especially when the cost is made lower through quantity production. There are many excellent treatises on topical therapy: two that are particularly rewarding are the Dermatologic Formulary of the New York Skin & Cancer Unit with Frances Poscher as editor; and Dr. Morris Leider's monograph in the May 1959 issue of *Medical Clinics of North America.*

Among some of the newer vehicles are the aerosols; tars, topical steroids, antibiotics and fungicides are dispensed in this form. The same is true of the foam preparations. The use of medicated and soothing baths and compresses have been simplified by improved packaging. Burow's solution, Vleminckx solution, d'alibour water, colloidal bran baths, and others are now easily and accurately made by using the commercially prepared individual envelopes or tablets. There are superfatted soaps such as basis and oilatum, soap substitutes Lowila® and pHisoderm®, medicated soaps Gamophen®, pHisohex®, and Mycoderm®. The newer shampoos: Capsebon®, Sebulex®, Betadine®, Dara®, and Domerine® to name a few have greatly facilitated the treatment of seborrhea capitis. Alpha-keri and travenol oils are very welcome aids in the treatment of icthyo-

*Read May 17, 1960, Atlantic City, N. J.

sis, hand eczemas, atopic eczema, and especially winter itch.

The introduction of griseofulvin is an outstanding example of medical progress. Due to this one drug, our whole concept of superficial mycoses has changed almost overnight.

ANOTHER remarkable achievement has been the development of the corticosteroids. Their influence on the treatment of skin diseases is tremendous. They cure nothing yet therapy is much more effective because of them. Perhaps their most rewarding sphere is in the treatment of acute dermatoses of relatively short duration such as dermatitis venenata and medicamentosa. Many minor applications of the steroids are helpful in daily practice. Painful aphthouh ulcers are greatly helped by dissolving half of a 25 milligram tablet of hydrocortisone in the mouth 3 or 4 times a day. Small sebaceous cysts, acne cysts, ganglia and mucous retention cysts can often be eliminated by injection of one of the preparations designed for intra-articular use. Alopecia areata also is helped by these injections and the danger of atrophy can be eliminated by not exceeding 0.5 cubic centimeters of the steroid in any one spot. Hypertrophic lichen planus, circumscribed neurodermatitis, and necrobiosis lipoidica diabetecorum also respond favorably to these injections and to the same material used in the vibro puncture technic. These corticosteroids have provided the first successful treatment for pemphigus, lupus erythematosus, exfoliative dermatitis, and intractable atopic eczema. It is in these diseases that require prolonged use of the steroids that we must be on the lookout for their undesirable effects. All of these undesirable effects are actually the normal physiologic action of the hormone and will be manifested in varying degrees by all members of the group if used long enough and in sufficient dosage. Thus the patient on prolonged therapy should be advised that he will react poorly to any stress situation such as infection, surgery, or injury and under such circumstances will require a temporary increase in dose.

Let us consider a few of the undesirable effects. The potassium excretion and sodium retention of cortisone and hydrocortisone have been nearly eliminated in the newer prednisone, prednisolone, triamcinolone, methyl prednisolone, and dexamethasone. Their ability to mask infection is notorious—the example is quoted of the patient with an overwhelming peritonitis going smiling to the autopsy table. They interfere with the formation of fibroblasts and ground substance and thus produce an osteoporosis that can result in fracture. By actually dissolving fibrous tissue they permit walled-off infections to spread. Moon faces and buffalo hump are produced by the redistribution of fat. In some cases this can be so extreme as to render the patient grotesque and to cause one to suspect a brain tumor. In patients with collagen disease, a pseudo-arthritis and cerebral edema can develop that is indistinguishable from lupus erythematosus. They can produce hydrocephalus in children. Habituation to these hormones is common and true addiction may require withdrawal. All of these and the other undesirable effects are reversible when the hormone is withdrawn. For everyone who suffers ill effect from a corticosteroid there are twenty living in blessed relief that no other medication available today can give them.

THE antimalarials are another class of helpful drugs. New uses are being reported almost every day. The major members of this group are Atabrine®, Aralen®, and Plaquenil®. They have a long history of safety in the treatment of malaria. The increased doses and prolonged use required in treating skin diseases have increased the incidence of side effects. The most common complaints were of severe burning in the mouth and epigastrium and a nausea and vomiting which sometimes persists long after stopping the drug. On prolonged therapy, reactions may be seen in the skin, eye, and central nervous system. Maculo-papular, lichenoid, and even exfoliative dermatitis, graying of the hair and even hair loss are seen. In the eye there may be blurring of vision, retenitis pigmentosa and

development of corneal opacities. Emotional reactions such as insomnia and toxic psychoses are found. Occasional leucopenia has been reported.

These toxic symptoms may appear so insidiously that their early detection is difficult. It is said that Triquin®, a combination of all three is less toxic than the individual members of the group. The most important use of these drugs is in the treatment of chronic discoid lupus erythematosus. They are remarkably effective even in severely scarred cases of many years' duration. Disseminated lupus responds less favorably but their use will often permit a reduction in the amount of adrenal-steroid required. They are very versatile drugs and are used to treat such a wide variety of conditions as dermatomyositis, polymorphous light sensitivity reactions, to reduce sunburn in fair-skinned individuals, molluscum contagiosa, poison ivy, verruca planae, acne, and rosacea. Generalized pruritis from many causes and in particular the vulvar pruritis of lichen sclerosus et atropicus may be relieved at times. It was recently reported that they have a "deslugging action" in veins that should make them useful in treating chronic leg ulcerations.

THE sulfonamides, long neglected, are once again proving their value. The new long-acting Madribon®, Medicel®, and Kynex® are very convenient because usually one tablet daily is all that is needed. Madribon® has been of great value in pustular acne, pyoderma, sycosis barbae, and impetigo. Kynex® is useful in dermatitis herpetiformis, but the ill effects on the skin and hematopoietic system have been somewhat frequent. Side effects for the most part have been mild, although bullous eruptions are reported. Just as with any sulfonamide, it is necessary to check periodically for leucopenia.

To the best of my knowledge, the tranquilizers have proved of very limited usefulness in dermatology. They sometimes are helpful in managing nummular eczema or atopic eczema.

Many of us have been disappointed over the years at the failure of the antihistaminics to live up to their first promise of help in allergic dermatoses. They have always been of some value but side effects (drowsiness in particular) limited their usefulness. The newer antihistaminics have reduced many of the side effects and are actually potent in relieving skin allergies. They deserve a trial in acute and chronic urticarias and atopic eczema. Not all skin allergies require corticosteroid therapy, and the newer antihistaminics should be used first.

There have been some improvements in our therapy of acne. The oral antibiotics and Madribon® are very useful. New cleansing agents like acne Dome cleanser, Brasivol® cleanser, and Fostex Creme® do a good job. The acne patient can now do a graded abrasion himself by using the new Brasivol®. This can be a very rewarding procedure. Aralen® is proving successful in selected cases of cystic acne resistant to more conventional therapy. Hydrocortisone or meticortelone injected locally will often cause involution of cysts. New elegance in local therapy is being provided by the drug industry. Cosmetically acceptable therapy and cover for the blemishes are provided by such products as Rezamid® lotion, Dermasul®, Sulforcin® base, acne Dome base, Acnomel®, and others. One renders these sufferers a real service by enabling them to conceal safely their malattractive skin.

The psoralens have two fields of usefulness. One in the treatment of vitiligo and the other in the prevention of light sensitivity dermatoses. They act in the first case by activating the melanin reaction and in the second by increasing the thickness of the stratum corneum. Unfortunately, redheads do not seem to get this increase in the stratum corneum so are not benefited by psoralens. There has been much concern over possible liver damage from their use but actually such damage is rare and occurs only when doses of 20 milligrams daily are exceeded. Fortunately the beneficial effects in both vitiligo and sun screening can be obtained by doses of 5 or at most 10 milligrams daily. An improvement in the management of vitiligo has been provided by the new product Man-Tan which affords better covering properties than potassium permanganate or walnut juice.

Not only the drug manufacturers but also those who make surgical and medical supplies and accessories of all kinds are providing us with new and useful products. Disposable gloves, syringes, plastic and paper drapes, and new towels are a great convenience and time saver. Webril® and Telfa® non-adherent dressings, plastic bases and tapes, Elastecon® porous adhesive tape, all make dressings easier and more attractive. Elastoplast® makes a variety of stretch forms for dressings to fit finger tips, knuckles, and so forth. Band-Aid® makes very handy sterile butterflies for wound closure. Johnson's Steripak® is a fine non-adherent dressing. It is worth a trip to your surgical supply dealer to see the great number of new products that can save you time in the office, and give you better results.

SUMMARY

MEDICINE has been passing through a period of revolution that shows no sign of slowing down. These antibiotics, hormones, antihistamines, and the others that we take for granted did not even exist just a few short years ago. We give a few pills or an injection and pemphigus goes into recession, syphilis is cured, and poison ivy clears. Continued research by medicine and all allied fields offers the sure promises of even more potent weapons in the fight against disease in the future.

70 Park Street

Skin Testing in Diabetics

Miller and Ridolfo* have found that skin testing with glucose oxidase test paper may be a simple way of discovering unknown diabetics in large-scale screening. After washing his hands in plain water the patient holds the wetted test paper with his forefinger and thumb for a minute. A change of color indicates glucose in the skin, which shows that there has been a rise in blood sugar some time previously.

Of 64 supposed nondiabetics tested, 11 had a positive skin test with negative urine and normal blood sugar; 7 of these had glucose tolerance curves indicative of diabetes, 2 had a borderline glucose tolerance curve and a pathologic cortisone-glucose tolerance curve, and in 2 no signs of diabetes could be found.

Of 86 known diabetics, 60 gave a positive skin test, alone or in combination with a positive urine or raised blood sugar. In 19 the skin test, urine and blood sugar were all normal, and 7 had a negative skin test while their blood sugar was raised and the urine in some cases was positive.

*Diabetes, 9:48.

Pre-Operation Radiation in Rectal Cancer

Pre-operative x-ray therapy in patients suffering from cancer of the rectum appears to be of limited benefit. It is useful in cases in which lymphatic spread of cancer is demonstrated. In these patients it increases the post-operative survival rate. An average tumor dose of about 2000 roentgens is used.

Patients in whom lesions were of borderline operability were given x-ray therapy before surgery. Therefore, in the group reported, there is a lower resectability rate in patients with pre-operative radiation. The selection was such that about 86 per cent of patients who did not have pre-operative x-ray treatment were resected, whereas only 69 per cent of those who did have it were resected.

There was no evidence of improvement of survival rate in patients discovered at operation to be free of lymph-node metastasis.

On the basis of the net benefits shown in these observations the authors* recommend pre-operative irradiation in rectal cancer.

*Stearns, M. W., Jr., *et al.*: Surgery, Gynecology and Obstetrics, 109:225 (July 1959).

Ralph A. Hall, M.D.

Westfield

The Rokitansky-Aschoff Sinus

X-Ray Sign of Chronically Diseased Gallbladders

A Rokitansky-Aschoff sinus is a small outpouching of the mucosa of the gallbladder. Dr. Hall believes that it signals a chronically inflamed and thickened gallbladder. He also suggests efforts at higher dye-concentration in cholecystography.

The literature on x-rays of Rokitansky-Aschoff sinuses is scanty enough to warrant the recording of two more cases.

Rokitansky-Aschoff sinuses in the wall of the gallbladder have been known for nearly a century in pathology laboratories. These intramural diverticula have been noted in normal as well as abnormal gallbladders. Robertson and Ferguson[8] reported that the sinuses are present in 42 per cent of normal gallbladders and 91 per cent of patients with cholecystitis. With the condition so prevalent, it seems remarkable that only 30 x-ray cases have been reported. It then becomes the problem of the roentgenologist to highlight this helpful sign. Actually, when seen, the shadows of the intramural diverticula give the investigator an accurate presurgical estimate of the thickness of the gallbladder wall. This gives evidence of the chronicity of the proliferative condition. This sign cannot always be elicited because of lack of concentration of the dye or the smallness of the diverticula apertures. About one-third of the cases seen by x-ray also contain calculi, and they seem to have their usual significance.[10]

Ross, Finby and Evans[10] adapted Robertson and Ferguson's classification of radiography as follows:

"Grade I. The diverticula extend to the muscular layer. This grade is not demonstrated by present radiographic methods.

"Grade II. The diverticula penetrate into the intermuscular lacunae and are seen radiographically as fine linear shadows of contrast material adjacent to and paralleling the contrast material in the gallbladder lumen.

"Grade III. The diverticula penetrate through the muscular wall into the underlying connective tissue, occasionally reaching the serosa. The radiographic picture is one of an irregular group of rounded densities about the lumen of the gallbladder."

The first radiographic case was reported by March[5] in 1948. Of the thirty reported since then, 75 per cent were in women. About fifty per cent give evidence of a constriction of isthmus near the mouth of the gallbladder. None of these constrictions seems to be sufficient to cause back pressure, however, if one is to judge by the ready reaction of the gallbladders to the fatty meals. Also the free way through the isthmus is relatively large. It is possible that this isthmus is important as a sign of chronically inflamed gallbladder in the absence of the diverticula. With the absence of other positive findings in either the stomach or the colon, and with a positive history, and (if one may ask for everything) a tender gallbladder, one could postulate a thickened, chronic cholecystitis. Both cases here presented are women. One case manifests an isthmus and the other does not.

CASE ONE

A 35-year old housewife complained of loss of weight, excessive sweating, and a lump in her throat after meals. She felt fine during the mornings and after breakfast until about ten o'clock.

Then intestinal pains began. These were aggravated one-half hour after lunch and supper. She indicated the pains to be rather "general," but especially in the lower right quadrant of the abdomen moving across to the left. There were occasional bouts of diarrhea.

Review of systems revealed frequent colds, bronchitis, occasional urinary tract infections, general malaise and fatigability. The patient had a long list of food allergies: apricots, lemons, raspberries, strawberries, lamb, eggs, American cheese, cocoanut, anise, caraway, clove, mushroom, and parsley. These cross checked with skin tests.

She was a 65.5 inch, 102 pound, red-headed, fair complected, underweight woman. Hemodynamics and laboratory, including blood count, urinalysis, sedimentation rate, VDRL, and electrocardiogram were normal except for an eosinophilia as high as 5 per cent.

Gastro-intestinal series revealed a small duodenal diverticulum which led to a low cholesterol bland diet with antacids with fleeting improvement. A barium enema was normal.

A gallbladder series using three grams iopanic acid (Telepaque®, Winthrop Laboratories, N.Y.) on two successive days revealed Rokitansky-Aschoff sinuses Grade II constricted gallbaldder which contracted to one-third its original size following the ingestion of egg yolk and glycerine (Cholestim, General Electric X-ray Dept., Milwaukee, Wis.)

One year after surgery the patient revealed that she had had no indigestion and could eat many things she could not eat before. The record revealed that there was less illness in terms of upper respiratory conditions and a greater sense of well being. She still complains of occasional diarrhea.

Figures 1 and 2 reveal the gallbladder in Case One before and after the fatty meal. The Rokitansky-Aschoff ducts are clearly seen around the sac. The isthmus is between the sac and the collum. The isthmus alone (in cases without the visible ducts) might be a suggestive sign in cases of chronic gallbladder.

CASE TWO

A 58-year old housewife said that she had "stomach and intestinal trouble" for thirty years. Chief complaint was right hypochondrial pain and intolerance to greasy foods with occasional intestinal cramps and diarrhea.

Review of systems revealed a list of allergies including chocolate, milk, eggs, tomatoes, and oranges. She was subjected to a tonsillectomy, exploratory surgery with removal of appendix, and wore a kidney pad for a "fallen kidney" for years. On the recommendation of another doctor the patient was taking large quantities of digestive enzymes and vitamins, especially Vitamin C. Arthritis had been a problem for which therapy had been of little avail. General malaise and frequent upper respiratory infections plagued the patient. There were occasional urinary infections. Severe headaches over these years were called tension, menstrual, and allergic.

She was a 64-inch, 133 pound brunette with grey boggy mucous membranes of the nose, and tonsillar tags. Otherwise, the rest of the physical examination, urinalysis, blood count, VDRL, and electrocardiogram were normal. X-ray revealed hypertrophic arthritis. Gastro-intestinal series revealed a sluggish stomach with a tender area above and to the right of the duodenal cap. Cholecystography following three grams of iopanic acid revealed Rokitansky-Aschoff sinuses Grade II nonconstricted bladder reacting to the egg yolk and glycerine meal to shrink to half size in 21 minutes.

Following surgery, the patient felt much better. Many foods she could not eat before became tolerable, and the enzymes were no longer needed. In the three months since the removal of the gallbladder she has had only two slight headaches. Never has she been so free of them. The patient continues on a low cholesterol diet and vitamins.

What might be coincidental similarities are here highlighted to shed whatever light possible on the constitutional makeup of the individual who reacts to a gallbladder infection in such a chronic proliferative fashion. Both patients were extremely allergic. Both complained of troubles that manifest a chronic "run-down condition" such as frequent upper respiratory diseases and urinary infections. The vague dyspepsia, intolerance of greasy foods, intestinal cramps and occasional diarrhea is understandable on the basis of a toxic absorption or production. It is not understandable in the face of the apparent normal function of the gallbladder unless the bile contains some sort of toxin for the intestinal tract. Certainly there is less gallbladder function after it is removed. Low cholesterol bland diet and antacids were of but fleeting effect and both patients improved after cholecystectomy.

SUMMARY

1. Visualization of the Rokitansky-Aschoff sinuses by x-ray appears to be a reliable sign of a chronically inflamed and thickened gallbladder.[13] It also appears that if the patient has symptoms referrable to the digestive tract that the physician can confidently recommend cholecystectomy.[10]

2. In doing cholecystography one should strive for high concentrations of the dye. Perhaps the double dye procedure should be more routine. For if this sign is more frequently visualized, relief may be brought to more patients that would otherwise be missed.

3. Another sign of value is the recognition of the isthmus in the absence of the diverticula.

Acknowledgments: I wish to thank G. McKay Stevenson, M.D., surgeon of Summit, N. J. and George Erdman, M.D., pathologist of Summit, N. J. for their help in developing this paper.

547 East Broad Street

BIBLIOGRAPHY

1. Alcorn, F. S. and Frank, R. J.: A.M.A. Archives of Surgery, 74:500 (February 1957).
2. Burt, L. I. and Masel, H.: Medical Journal of Australia, 1:270 (February 19, 1955).
3. Carlo, J. P. and Gentneer, B. A.: American Journal of Roentgenology, 79:872 (May 1958).
4. Halpert, B.: Bulletin of the Johns Hopkins Hospital, 41:77 (August 1927).
5. March, H. C.: American Journal of Roentgenology, 59:197 (February 1948).
6. Moore, R. D.: American Journal of Roentgenology, 75:360 (February 1956).
7. Risk, W. S.: A.M.A. Archives of Surgery, 73:775 (November 1956).
8. Robertson, H. E. and Ferguson, W. J.: Archives of Pathology, 40:312 (November 1946).
9. Rosenbaum, H. D.: Journal of the Kentucky Medical Association, 53:956 (November 1955).
10. Ross, W. D., Finby, N. and Evans, J. A.: Radiology, 64:366 (March 1955).
11. Sante, L. R.: Principles of Roentgenologic Interpretation, Edwards, Ann Arbor, Mich. (1945) pages 289 through 293.
12. Shanks, S. C. and Kerley, P.: A Textbook of X-ray Diagnosis. Philadelphia 1952. Saunders. Volume 3. Pages 445 through 487.
13. Sukman, R. and Daron, P. B.: Radiology, 60:714 (May 1953).

Robert S. Garber, M.D.

Belle Mead

The Role of the Private Psychiatric Hospital in Meeting the Needs of a General Medical Community*

The private mental hospital has another function, too. It assuages the guilt-feelings of relatives who are reluctant to send a patient to a public hospital.

The private psychiatric hospital in America has been in existence almost as long as the general hospital. We can point with pride to such hospitals as the Friends Asylum, the second hospital in America, devoted solely to the care of the mentally ill, established in 1817; the Institute of the Pennsylvania Hospital; Bloomingdale; McLean; the Hartford Retreat; Butler and also to personal names like Kirkbride, Nehemiah Cutter, Pliny, Earle, Isaac Ray, John Butler and Luther Bell. At the founding of the American Psychiatric Association, *seven of the original thirteen members were representatives of private institutions.* Thus, the concept of a private psychiatric hospital is nothing new.

On the other hand, the present day function of the private psychiatric hospital differs widely from those established many years ago. These early private endeavors offered the only places where true asylum could be obtained. There was no treatment as we know it today, just asylum. The few who could be admitted were fortunate. The vast majority were held in the American versions of almshouses and jails. Private institutions originally served as custodial places for the seriously disturbed emotional illness of wealthy families and offered splendid and plush circumstances in a well protected and secure environment. Today, very few of our private psychiatric hospitals function in this manner.

The present-day version of a private psychiatric hospital is a far different one. Increasing awareness of emotional and mental illnesses has prompted many of our citizens to accept psychiatric care much earlier than ever before. Subsequently, the private psychiatric hospital has been molded to meet the needs of the general medical community, much more than many public hospitals. This stems from a number of different reasons, but principally from the fact that the private psychiatric hospital is a smaller unit with higher personnel-to-patient ratios, able to gear its therapeutic programs for efficient expediency, thus enabling a patient to return to his home, family and community in a relatively brief time. Actually, such programming meets the demands of a therapeutic community, particularly where prepaid medical-surgical plans underwrite the cost to the family. In such a fashion, expediency is the watchword and consequently there is less tendency toward chronicity of the prob-

*Read May 17, 1960 at the Annual Meeting, The Medical Society of New Jersey, Section on Neuropsychiatry.

lem since the patient is sooner returned to his own environment, thereby re-establishing ties with the family constellation and with little interruption of his socio-economic situation.

For the sake of clarification this paper will deal only with those private psychiatric hospitals listed by the National Association of Private Psychiatric Hospitals, most of which are approved by the Joint Commission of Accreditation of Hospitals and/or The Central Inspecton Board of the American Psychiatric Association. These hospitals are concerned with every type and ramification of psychiatric illnesses. Many are organized along the lines of a medical Battalion Aid Station serving as the first line of defense to deal in an expedient fashion with acute psychiatric illnesses and the prompt return to the combat (conflict) area; only those patients whose illnesses are considered to be of long-term nature filter through the Battalion Aid Station to the rear echelon, namely the public or state hospitals. On the other hand, most private psychiatric hospitals serve a more utilitarian purpose, accepting both acute as well as chronic (or long-term) psychiatric disorders and offer therapy tailored to meet both types of patient. Others offering specialized types of private psychiatric management, as *e.g.*: those dealing with childhood illnesses wherein such hospitals offer their own schools or transportation to community schools nearby. There are those whose facilities are adolescent-centered; those geared only for geriatric problems and others which are more specialized concentrated centers for particular illnesses such as drug addiction, alcoholism, or problems that do not require a complete psychiatric setting. In addition, some private psychiatric hospitals offer day hospital facilities, night hospital facilities, or those to care for week-end problems.

STAFF PATTERNS

GENERALLY speaking, most of the hospitals have "closed staff" arrangements with full time staff psychiatrists on salary with or without the privilege of seeing their own patients privately at the hospital; a smaller proportion of hospitals operate on an "open staff" arrangement where only the Medical Director and the Administrator-Business Manager are on salary. Here the referring psychiatrists in the community send in and treat their own patients.

THERAPEUTIC PROGRAMS

IN VIRTUALLY every instance all such facilities offer every known type of acceptable therapy which ranges from the psychopharmacologic agents to the various forms of shock therapy and psychotherapy (brief, intensive, analytical and hypnosis).

The reception of the admissions is generally managed through the benefit of a trained psychiatric social service staff whose principal function is to arrange for a smooth admission of the patient to the hospital as well as to pave the way for return to the home and community and to set up appropriate after care treatment.

RESEARCH

IN SUCH hospitals research often goes hand-in-hand with the therapeutic program. This may range from modified efforts to intensive research development wherein full time staff of various professional levels are employed exclusively for such purposes.

EDUCATION AND TRAINING

TRAINING programs ensue throughout and are geared to offer approved training for psychiatric residents, general practitioners, student nurses, psychiatric technicians, laboratory and x-ray technicians as well as occupational and recreational therapists. The training program in these hospitals is frequently overlooked by those who give the impression that they do not want private hospitals to continue in their present form and function. Several score newly trained psychiatrists leave

these hospitals every year trained at no cost to the taxpayer. This training program is different from that offered in a large governmental hospital or in the academic atmosphere and provides a different viewpoint. It stresses a kind of patient-relative-physician education relationship that is not stressed in other teaching units.

The hospitals also serve an important role in the area of community education by offering an active speaker's bureau, that is, a panel from all professional levels who are available to speak to any local organizations. Professional staffs of the hospital may also offer a multitude of free services, serving as psychiatric consultants for neighboring general hospitals or conducting psychiatric clinics in space provided by such hospitals. In many more instances a large proportion of private hospital staffs are actively involved in professional teaching in nearby medical schools, and many of them enjoy faculty appointments.

CONSULTANT SERVICES

VIRTUALLY all hospitals employ a large number of consultants in every specialty so that their full time staff psychiatrists are not burdened with the necessity of evaluation of the frequently found medical and surgical problems which must be clarified in order properly to classify the patient's physical and emotional status, but rather may rely upon currently trained professionals in the various specialties to augment and enhance their own opinions.

ADMISSISON TYPES

NOT generally known is the fact that the intake of private psychiatric hospitals is made up of 90 per cent voluntary admissions. The admission rate for these hospitals is frequently in larger numbers than in many public hospitals. For example, a 90 to 100 bed private psychiatric hospital and a 3000 to 5000 bed public hospital are frequently found to be admitting from 11 to 14 hundred patients per year in each. Thus, the length of residence in the private hospital averages about 20 days in comparison to a much longer residency period in the public hospital. According to the U. S. Department of Health, Education and Welfare, 293 private hospitals were listed of which 209 of these were reporting. This number accounted for 72,317 patients while 29 per cent of them did not report so we might assume that the private hospitals admitted over 100,000 patients that year. On the other hand, the 277 public hospitals admitted only 194,772 in facilities that have over 30 times as many beds in their hospitals as there are in private hospitals. When one considers that of the 530 psychiatric units in general hospitals, 350 reported a total of 181,758 admissions, it should be apparent that if all private hospitals were closed tomorrow it would cost the taxpayers many millions of dollars to build admission departments to care for the patients that are admitted and treated in private facilities.

FACILITIES

PRIVATE psychiatric hospitals continue to offer (sometimes in a smaller version) all the facilities offered by larger components, *i.e.*, complete x-ray and laboratory functions in the various conjunctive medical services to aid in the comprehensive diagnostic evaluation of their patients. Most private hospitals are in attractive settings far removed from the usual urban areas with ample acreage and in exceedingly pleasant circumstances totally open in their environment. Rarely do they offer the appearance of a public hospital for the mentally ill; particularly because many private psychiatric institutions have been functioning on an "open hospital" basis for many years. The spaciousness of the facilities readily available both for occupational and recreational therapy offer the "vacation-like" environment particularly enjoyed by a number of patients who could never have had this opportunity when hospitalized in psychiatric services of some general hospitals in urban centers which may afford little opportunity for such privileges.

ADVANTAGES OVER GENERAL HOSPITALS

THE atmosphere of the private psychiatric facility has distinct advantages since it is totally devoid of the hurly-burly of some general hospitals, and its total personnel are trained in psychiatric principles and practices. Such personnel available on a 24-hour basis can do much to avoid the "emergency" that frequently arises in some general hospitals when the staff is confronted with a suicidal patient and the usual procedure is to strip down a room and place non-psychiatric personnel "on guard" with the patient, only increasing the anxiety of all parties concerned. In contrast to this, the private psychiatric hospital with properly oriented personnel, can offer a more tranquilizing effect on their patient population by displaying equanimity in the management of such patient problems. Further, greater freedom of movement about the buildings and grounds cannot help but provide a more therapeutic environment.

CONCLUSIONS

PRIVATE psychiatric hospitals are now giving psychiatric treatment openly to their neighbors. The demand for isolation and anonymity no longer exists in our society which is gradually awakening under the pressures of both need and education. Today the psychiatric specialty hospital is a community service hospital in the same sense that the general hospital serves its immediate community. Because of their flexibility, smaller size, and their relaxed environment, they not only meet the individual patient's problem with dignity and adaptability but are so organized as to give room to imaginative and progressive treatment. They are truly hospitals rather than "institutions." In such a way they deal with a multitude of acute emotional disturbances in a prompt and expedient fashion, returning many thousands of patients in a comparatively brief period of time to their homes after a pleasant sojourn in a proper environment, which did not rob them of their individuality nor label them with any stigma as a result of their experience. Probably the greatest reflection of this trend is the fact that there is an ever-increasing number of referrals from former patients as well as from general practitioners, who, not so many years ago, had no more than a superficial knowledge of psychiatric problems. It is to the credit of the extensive psychiatric training programs now being offered to the general practitioner by many of the private psychiatric hospitals, that this very important core of the medical association has been enabled to see the need and demand for proper management of these ever-increasing problems confronting them in their every day practice. The private hospitals are a stronghold of free enterprise in the total medical field and especially in the practice of psychiatry. They provide training centers which stress the private practice of psychiatry without depending on tax money to finance their program. They have, in the past, worked diligently toward self-improvement and will continue to do so working toward better facilities and better therapy through self-criticism and research.

The Carrier Clinic

REFERENCES

1. Robinson, W., Jr.: The Purposes and Objectives of the Private Psychiatric Hospital. Kansas City Medical Journal, XXX (May) 1954.

2. Robinson, W., Jr.: The Current Role of the Private Psychiatric Hospital. Diseases of the Nervous System, XXI (Feb.) 1960.

3. Neumann, T. W., Jr.: The Private Hospital and the Community. Mental Hospitals (June) 1960.

George P. Potekhen, M.D.

Plainfield

Anesthesia Coverage in Obstetrical Service*

Since deliveries (unlike operations) are rarely scheduled, the problem of making available round-the-clock anesthesia service is a challenging one. Here is one practical solution to the problem.

This is a report of how the anesthesia department at the Muhlenberg Hospital provides coverage for the obstetrical service. Our hospital is in Plainfield, N. J., serving a population of about 100,000. Muhlenberg is a 400-bed hospital with 62 beds and 62 bassinets available to the obstetrical staff. In 1958, there were 4106 deliveries in our area. In 1959 the number was 3837. In each year, we averaged more than 10 deliveries a day. I became associated with Muhlenberg in 1948. In that year, the hospital did 2100 deliveries. The anesthesia service then (and now) was totally supplied by physicians. Several general practitioners were interested in this work and they were both available for morning hours. They alternated on evening and night coverage. With this simple arrangement, coverage was excellent.

The general practitioners gradually became very busy. During the last 3 years it was felt that the anesthesiology division would have to undertake the coverage which entailed more time and energy with the rapidly enlarging obstetrical staff and the great increase in deliveries done at Muhlenberg.

At one period, I alternated with a general practitioner to cover the night work from 10 p.m. until 7 a.m. We would be on this schedule for one week, then be off the next week. This period stands out in my mind as a constant effort to stay awake. I would work in the operating room during the day and cover obstetrics at night. I can sincerely testify that this is a very poor arrangement.

The anesthesia division has gradually evolved from a 3-man staff to a group of 6 full-time anesthesiologists. The work load on each man has decreased considerably.

One general practitioner still covers the morning hours from 7 a.m. until 6 p.m. He has been doing obstetrical anesthesia for many years and can give a good general anesthetic to the parturient patient. He has also agreed to cover the schedule for two of our full-time anesthesiologists whose health prevents them from participating in the night coverage. In the past three months we were lucky enough to obtain the services of an anesthesiologist willing to cover obstetrical anesthesia when he was free from his duties at another hospital. This arrangement terminated in March 1960.

The daily 7 a.m. to 6 p.m. period is covered by the general practitioner. He also will cover the 6 p.m. to 7 a.m. period at various times in place of an anesthesiologist who might not be able to devote his allotted period to the obstetrical service. Arrangements have been made so that he may be free on alternate weekends.

The general operating room emergency schedule is covered by the six anesthesiologists

*Read May 18, 1960 at Atlantic City before the Section on Anesthesiology, Annual Meeting of The Medical Society of New Jersey.

on the basis of a roster. The day after his tour of duty on emergency call, he becomes the "second on call" and covers the obstetrical floor from 6 p.m. to 7 a.m. Emergency sections are done on the obstetrical floor and are the responsibility of the doctor on call.

The second doctor on call (following his tour of duty and work load permitting) is then free of all anesthesia duties on the following day. Here is how it works:

First Day: On operating room call.
Second Day: Second call for obstetrical service. (6 p.m. to 7 a.m.)
Third Day: Off duty.
Fourth Day: Same as first day.

and so on.

This general schedule is adhered to even during vacation periods. Excellent rapport on the part of all persons involved has made this a very workable and non-fatiguing arrangement.

The past years have shown a great increase in the number of obstetrical cases at Muhlenberg Hospital. The greatest need at present seems to be adequate, safe, and dependable anesthesia coverage for the general hospital.

In 1959 our obstetrical anesthesias were:

3044 general anesthesias for vaginal deliveries
352 general anesthesias for sections
316 saddle blocks
24 spinal anesthesias for sections
4 epidurals
1 general supplemental to saddle block

There have been no maternal deaths attributable to anesthesia. Infant salvage has been very good. Most saddle blocks are administered by the obstetricians.

Ward patients are under the direct supervision and presence of a staff anesthesiologist. Some mothers deliver so rapidly that no anesthesia is used; but we are all available within 10 minutes or so. An occasional "natural childbirth" is requested. Perineal blocks by the obstetrician are also employed on numerous occasions; but on the whole, the anesthesiologists are present for all the deliveries as noted.

The anesthesiologists of Muhlenberg Hospital are doing their utmost to refute such figures as noted in *Scope Weekly* (Nov. 11, 1959) that "Infant Mortality at Highest Level for Last 6 Years!" In the November 1959 *Modern Medicine* there was a discussion of pudendal blocks. This reiterated the importance of good anesthesia and points out how, in its absence, the saddle block is the technic of choice. As Donnelly[1] says, anesthesia is one of the critical matters in deliveries. Little[2] critically discusses the various technics involved. Eastman[3] recently reviewed the evolution of obstetrics but did not emphasize the importance of the concurrent evolution of anesthesiology. Nesbitt[4] could have given a little more credit to the anesthesiologist as an important facet of newborn anoxia problems. Cull[5] reported on the coverage of a hospital with an obstetrical load like that at Muhlenberg.

HOPES FOR THE FUTURE

1. The physician anesthesiologist, like the obstetrician should be dedicated to giving the best possible care to the mother and baby, by night as well as day.

2. Anesthesiologists must be educated about the importance and need for the service; and should be taught the important differences between obstetrical and surgical anesthesia.

3. The obstetrical staff should be educated concerning the need of the service as well as primed on the idea of a fee-for-service medical anesthesiologist.

4. Patients could be better educated by their obstetricians concerning the merits of our services.

5. Interns and young physicians entering practice could be indoctrinated in the needs and possibly interested in the field, if remuneration were comparable to that received by obstetricians, surgeons, and anesthesiologists in private practice.

Acknowledgment is made to Miss Nancy Grygent, R.N.B.S., Delivery Room Supervisor for her statistical assistance.

Muhlenberg Hospital, Plainfield

Bibliography will be furnished by the author on request.

JOHN C. WHITAKER, M.D.

Riverton

Depression in Middle-Aged Patients

Every family doctor has to treat middle-aged depressed patients. Often, referral to a psychiatrist may be impractical. In such cases, a combination of trifluoperazine and tranylcypromine, in Dr. Whitaker's hands, proved remarkably effective.

NO ONE passes through the middle years of life without frustration, disappointment, unhappiness and, sometimes, grief. A surprising number of people, however, are unable effectively to handle these discouraging experiences. Some yield to the emotional pressure and plunge into depression. The process is subtle, and the severity of the depression varies widely. Many complain of little more than loss of vitality and initiative. In extreme cases, however, a patient may ruminate on his shortcomings, and, believing his life an effort without reward, he attempts to destroy himself.

The depressed patient frequently has symptoms of anxiety. He may express concern over "what's happened" to him. When he cannot raise his spirits, or when morbid thoughts creep into his mind, he may grow tense. If the tension persists, he is further discouraged and depressed. A morbid cycle thus begins. When the patient finally emerges from his depression, symptoms of anxiety may appear when he again tries to cope with problems he could not previously manage.

The course of a depression can usually be conspicuously shortened by treatment, even though its causes remain unmodified. A new approach to this treatment is therapy with a combination of tranylcypromine and trifluoperazine.

Tranylcypromine [1] is a monoamine oxidase inhibitor [2] reported effective in the treatment of both severe and mild depressions.[3] Trifluoperazine is a phenothiazine tranquilizer [4] reported effective in the treatment of anxiety [5] particularly when it manifests itself as agitation.[6] Both drugs were reported to have minimal side effects in the doses studied.

CASE MATERIAL

A STUDY of 53 patients treated with this combination of drugs is described in this paper. It was done at the request of Smith Kline and French Laboratories to help evaluate the efficacy of the combination as supportive treatment in the therapy of depressed patients.

The patients in this study, 35 women and 18 men, ranged in age from 34 to 60; average

1. Petersen, M. C. and McBrayer, J. W.: Am. Journal of Psychiatry, 116:67 (July, 1959).
2. Maass, A. R. and Nimmo, M. J.: Nature, 184 (4685, Suppl. 8): 547 (August 15, 1959).
3. Investigational Use Circular. Smith Kline & French Laboratories (September, 1959).
4. Gearren, J. B.: Diseases of the Nervous System, 20:66 (February, 1959).
5. Proctor, R. C. and Gunn, C. G., Jr.: *Trifluoperazine: Further Clinical and Laboratory Studies.* Philadelphia 1959. Lea & Febiger, pp. 28-36.
6. Kovitz, B.: Management of Psychotic Symptoms with Trifluoperazine, in *Trifluoperazine: Clinical and Pharmacologic Aspects,* Philadelphia, 1958. Lea & Febiger, pp. 144-149.

age 45. They lived in a small town in New Jersey and were "upper middle-class," educated people of average to high intelligence.

Two groups of patients were treated: in one group were 26 patients—23 women in the menopause and 3 men in the climacteric. In the other group were 27 psychoneurotics—14 women and 13 men—with symptoms of depression and anxiety, anxiety predominating.

SYMPTOMS

THE patients complained of a number of emotional and psychosomatic symptoms which had bothered them for three months to fourteen years; average two years. In general, their reactions to life situations were considered evidences of depression or anxiety only when they seemed excessive for the provoking incident, or when they persisted unduly long. Depression was usually revealed by the patient's remarks, typical of which were the following: (The remarks are of course not diagnostic of depression, but only signal the possibility.)

". . . everybody I knew has died or moved away . . . town is full of people I've never seen before . . ." This suggests *loneliness*

"All I seem to do is nag and snap and pick . . . and the least noise infuriates me." This suggests *irritability*

"Everything's fine. I don't know why I *feel* so bad." This suggests *depression*

". . .I have to drag myself to market . . . it's such an effort . . ." (*fatigue*)

"I don't deserve to be married to so fine a person . . . he'd be better off without me. I hold him down . . . (*unworthiness*)

"My mother slaved for us, and how do I pay her back? By treating her like some useless thing . . ." (*guilt*)

"Some men just haven't got it and never will. So, what's the use of trying?" (*discouragement*)

"*Nobody* can help me." (*hopelessness*)

". . . disease and death are all around, in the food we eat, on the roads . . ." (*gloom*)

Symptoms of anxiety were suggested by these typical remarks:

"I want to scream and cry, for no reason . . . . . often . . ." (*tension*)

"I shake all over but I can't see any movement . . . it's inside . . ." (*jitteriness*)

"I can't sit still . . . when people are in my house I flutter around like some silly old woman. It's worse when I'm alone. I have nothing to distract me." (*restlessness*)

"The more I produce the more they demand—I can't keep it up." (*anxiousness*)

"I can't even read. Gloomy thoughts pull me away." (*inability to concentrate*)

In addition to emotional symptoms, women patients in the menopause had one or more of these vasomotor symptoms—flashes, flushes, fainting, tachycardia, headache or vertigo.

Four menopausal women complained of joint pains; one had periodic migraine headaches, one pruritus.

One woman had had a hysterectomy, including oophorectomy, six year before. One man had surgery for cysts on the testicle; following this he thought himself impotent. Three women and two men had psychosomatic symptoms including headache, shortness of breath, gastric irritability, constipation and flatulence. None of the patients had organic disorders to which their symptoms could be attributed.

PREVIOUS THERAPY

THIRTY-TWO had received previous treatment for their emotional symptoms. Most had had some form of supportive psychotherapy. Medication included amphetamines, barbiturates, meprobamate and prochlorperazine. One patient had received norethandrolone, one received triiodothyronine, one phenelzine (which is a monamine oxidase inhibitor) and one trifluoperazine. Two patients with cyclothymic personalities had received courses of electroconvulsive treatments several years before and had had satisfactory remission of symptoms.

Two men had received testosterone (20,000 units), and two women had received estrogens (20,000 units) every two to three weeks for a year. These menopausal patients treated with hormones had had some remission of symptoms (notably vasomotor) and the anxiety associated with them.

Most of the patients who had received previous treatment had *not* responded satisfactorily. Although some improvement was noted, it was either transient or incomplete. Further treatment was usually indicated. For example, the patient who received phenelzine, a 41-year old psychoneurotic with anxiety and underlying depression, was somewhat improved after treatment but his symptoms of anxiety were still marked. And the patient who had received trifluoperazine, a 40-year old psychoneurotic who had been depressed and anxious, was relieved of some anxiety after three weeks of treatment with a milligram of trifluoperazine twice a day but was still depressed.

TREATMENT

THE patients were all started on one tablet of the combination of tranylcypromine (10 milligrams) and trifluoperazine (1 milligram), twice a day. Two men who had been receiving testosterone (20,000 units intramuscularly every three weeks) were continued on it. Five patients were given multivitamins as nutritional supplemental, and one patient with secondary anemia was given a hematinic.

The patients received one tablet of the drug twice a day for periods varying between three weeks and four months. The average duration was six weeks; twelve (or half the patients) were treated for five and seven weeks. Dosage was reduced to one tablet daily in six patients after two to three weeks. Dosage was increased to two tablets, twice a day, in two patients after two to three weeks. All patients were seen at intervals of seven to ten days for the first month; and at intervals of two to three weeks thereafter. Supplies of medication were limited to last only three weeks so the patients had to return (and be examined) before receiving another supply.

No formal psychotherapy was given. We discussed problems of middle age, and they got some release of emotions telling their troubles during visits; but no attempt was made to probe the underlying causes of their depressions.

Most patients had one symptom which concerned them more than others. This symptom was concentrated on both in treatment and evaluation of results achieved. For example, one 40-year old man who worked on the editorial staff of a magazine, suffered primarily with tension. He said, "The tension never stops. Sometimes I work off a little, say a few things when I'm drinking, but it (tension) builds up again—quickly. It's always there... drives me wild when I try to get rid of it and can't." He had had a partial gastrectomy for an ulcer nine years previously, and had had sporadic episodes of depression throughout his life. His tension bothered him most, so during treatment, exacerbation or remission of this symptom was followed closely. It served primarily (though of course not exclusively) as the basis for deciding what progress, if any, he made.

Liver function tests were done on 16 patients since liver dysfunction has been reported in some patients treated with monamine oxidase inhibitors, or with phenothiazine derivatives. Tests were done on eight patients treated for one to two months, and eight patients treated for two to three months. At three- and six-week intervals, alkaline phosphatase and serum glutamic oxaloacetic transaminase (SGOT) were measured. These tests were selected because they are reliable, sensitive indicators of liver dysfunction, particularly that for SGOT which may rise from normal levels of zero to 44 units to levels as high as 30,000 units in toxic hepatitis.[7]

RESULTS

RESULTS of therapy were evaluated from changes in the patients' emotional and psy-

7. Van Rymenant, M. and Tagnon, H. J.: N. Eng. J. of Medicine, 261:1374 (December 31, 1959).

chosomatic symptoms. The following criteria were used:

Much Improved—patients who no longer complained of symptoms they had at the start of treatment; whose behavior and appearance confirmed the reported remission, whose attitude reflected reasonable confidence and hope.

Partly Improved—patients whose symptoms bothered them less, or who complained of fewer symptoms; or were less apprehensive about their symptoms or their illness; their outlook reflected better acceptance of themselves and their life-situation. Patients in whom symptoms of anxiety predominated were less apprehensive, appeared less "driven," and did not have any exacerbation of depressive symptoms as their anxiety waned.

No Change—patients who had little increase or decrease in the severity of their symptoms. Their moods varied somewhat, but their *range* of feeling remained narrowed.

Results at the conclusion of treatment are shown in the table.

Twenty-seven of the 53 patients treated were much improved; seventeen were partly improved; seven showed no change. Two (who proved to be manic-depressive personalities) grew worse and had to be hospitalized. These two were not the two manic-depressive psychotics who had previously received ECT and who—in this study—were both much improved after two months of treatment with the combination of drugs.

In six patients whose improvement was maintained for two to three weeks, dosage of the drug was reduced from two tablets a day to one tablet a day. Five maintained their improvement on the lowered dose; one seemed not to fare well on the lowered dose, and was given one tablet twice a day.

Three patients who had been on amphetamines before being switched to the combination of drugs each gained about five to ten pounds.

SIDE EFFECTS

A TOTAL of 11 patients (21 per cent) had side effects from the drug. These were as follows: insomnia, 3 patients; severe headache, 3; motor restlessness, 2; nausea, palpitations, 2; "light-headedness," 1 patient.

Three patients complained of severe headaches which had lasted up to four days. All had relief from their headaches when the dosage was reduced to one tablet a day. Atropine and meperidine were given to one man for immediate relief of a particularly severe headache.

Two patients had motor restlessness. Medication was discontinued in one. The other patient stopped taking the drug and did not return for further treatment.

Three patients complained of insomnia which they had not had before treatment, and required reduction in dosage to one tablet daily. One of these patients was no longer troubled by insomnia even after her dose was subsequently increased to one tablet twice a day. Another of these three patients was maintained at one tablet daily because her dose could not be increased without reappearance of insomnia. The third patient continued to have insomnia even on one tablet daily and, although her psychic symptoms had improved, medication was discontinued.

One patient had palpitations which disappeared when the dosage was reduced to one tablet daily. One had nausea and palpitations

	Much Improved	Partly Improved	No Change	Worse	Total
Depression with menopausal or climacteric symptoms	15 (60%)	9 (33%)	2 (7%)	0	26 (100%)
Anxiety reaction	12 (45%)	8 (30%)	5 (18%)	2 (7%)	27 (100%)
All patients	27 (51%)	17 (32%)	7 (13%)	2 (4%)	53 (100%)

which persisted even after dosage was reduced. Her medication was discontinued. One complained of "light-headedness." Dosage was reduced to one tablet daily in her case, and the symptoms stopped (concomitantly with marked improvement of her psychic symptoms).

A 20-millimeter reduction of systolic blood pressure was noted in two patients after two weeks of treatment. Neither had clinical symptoms of hypotension.

Liver function tests on 16 patients indicated normal function during therapy; alkaline phosphatase measurements were between two and nine Bodansky units; SGOT between eight and forty Sigma-Frankel units.

CASE HISTORY

A forty-year old man complained he had been tense, nervous and depressed for six months. For several weeks before coming for treatment he had been feeling very tired. A linotype operator for a small print shop in town, he felt "compelled to keep busy." His outlook on life was bleak. He had had episodes of depression all his life. These were more frequent after an operation ten years before. This operation was a partial gastrectomy for a peptic ulcer. Recovery and subsequent course were uneventful. No new ulceration had taken place since then, but he was bothered by "indigestion," constipation and flatulence, and vague abdominal pains. Diagnosis was anxiety state and depression. He had been treated three months before with trifluoperazine, 1 milligram twice a day for three weeks with some improvement, notably in his symptoms of anxiety, but his depression persisted.

He was given a tablet of the combination of tranylcypromine and trifluoperazine twice a day and seen a week later. He said some of his tension was eased on the second day and he had slept better during the week. He continued on the combination and, two weeks later, was much improved. He felt less "driven" to keep busy, and less moody, and he seemed to be encouraged by the relief he had enjoyed for several weeks. A month later, seven weeks after the start of treatment, he was still much improved. His attacks of nervous indigestion were less frequent, and he no longer complained of flatulence or abdominal pains. His outlook had changed noticeably. His despondent thoughts had disappeared and he felt "himself again." Because of his long history of depression he was continued on the drug, but at lower dosage (1 tablet daily) for another two weeks before treatment was concluded.

COMMENTS

1. One objective in treating depressed patients is to bring about some relief of symptoms as soon as possible, to interrupt a morbid process which may unexpectedly gather speed. It is a primary objective in patients who benefited only slightly from previous treatment and are still depressed. These patients are often pessimistic about efforts to relieve their depressions, and gain some confidence when even slight improvement takes place quickly.

Patients in this study who improved began to have relief of symptoms two to five days after the start of treatment, probably as a result of action of the trifluoperazine. This was some five to seven days sooner than previously observed with other antidepressants. The relatively rapid onset of action was an advantage when patients were switched from other medication; transition was not abrupt.

In all but one case, the therapeutic effects of the drug persisted when the dosage was reduced.

2. Patients in this study who improved were aware of an amelioration of mood associated with relief of symptoms. None reported overstimulation. The benefit of rapid improvement in depressed patients may be diminished if the patient feels himself overstimulated by the drugs he is taking. For example, the combination of amphetamine and amobarbital rapidly ameliorates mood, and is effective therapy for many mildly depressed patients; but it may induce an exaggerated and transient sense of well-being which seems artificial to some depressed patients.

3. The combination of two drugs used in the study has the disadvantage all combinations have—proportions of the drug are fixed for the requirements of most, but not all patients. None of the patients in this study required supplementary doses of either of the two drugs, but some patients probably will.

4. Only a few of the depressed, middle-aged people I see in my practice can be referred to psychiatrists; most, including those who have had psychotic episodes, must be tided over depressive episodes with supportive therapy, primarily medication. Results of this study are encouraging since they suggest the combination of tranylcypromine and trifluoperazine can effectively control symptoms of anxiety as well as depression. By alleviating symptoms and shortening the course of the depression, the drugs seem to permit the patient to again mobilize his emotional resources. The drugs should, therefore, prove very useful for the treatment of emotionally disturbed patients in general practice.

SUMMARY

FIFTY-THREE depressed, middle-aged people, half of whom were in the menopause or climacteric, were treated with a combination of tranylcypromine and trifluoperazine for three to 16 weeks. Results achieved in these patients were an improvement over previous therapy with tranquilizers and antidepressants alone. Symptoms of anxiety and depression were completely relieved in 27 patients, partially relieved in 17, unchanged in seven. Two patients had to be hospitalized. Side effects were seen in 11 patients (21 per cent); medication was discontinued in three. Liver function tests performed in 16 patients revealed no dysfunction.

402 Lippincott Avenue

Physician Increase Notable in New Jersey

The AMA Council on Medical Education has released a report on distribution of physicians. The report will be found in the May 28, 1960, Journal of The American Medical Association. Here are its highspots:

The physician population of the United States and its possessions increased by 4,769 in 1959.

This was an increase of 660 over the gain reported in the previous year. The increase results from the licensing of 8,269 new physicians minus 3,500 physicians who died.

Of the 8,269 new physicians, 1,626 were foreign trained.

The largest number of first licenses issued was 1,121 by New York. Three other states issued more than 500 first licenses—California 676, Illinois 521, and Pennsylvania 530.

The most notable increases, compared with 1958, were in New Jersey, Puerto Rico, and Tennessee. There was no *marked* decrease in any state.

Licenses to practice medicine and surgery issued in 1959 were 15,954. This represented 7,720 granted after a successful written examination and 8,234 granted by reciprocity or certificate of the National Board.

There were 8,996 applicants for licensure by written examination of whom 13 per cent failed. This may be compared with 8,633 applicants of whom 16 per cent failed in 1958.

The 8,996 examinees included 5,845 graduates of medical schools in the United States; 178 graduates of medical schools in Canada; 2,766 graduates of 244 facilities of medicine in countries other than the United States and Canada; 22 graduates of the unapproved medical schools in the United States no longer in existence, and 185 graduates of schools of osteopathy.

The number of physicians registered in 1959 was 16,068, the greatest number in 56 years.

ALBERT EHRLICH, M.D.

Hoboken

Hyperbilirubinemia Due to Exchange Transfusion in the Newborn*

Group O blood is commonly used for exchange transfusion in hemolytic disease of the newborn regardless of the blood group of the baby. The Anti-A and Anti-B isoagglutinins of the group O donor blood causes hemolysis of the infant's remaining A or B cells. The resulting hyperbilirubinemia necessitates multiple transfusions.

It is a common practice to use group O Rh negative blood, regardless of the baby's blood group, in exchange transfusion in the newborn, due to Rh hemolytic disease. The advice of some experts [1] in the field, is to crossmatch the donor's cells against the mother's serum.[2] A problem arises in 20 per cent of all pregnancies, when the baby is group A or B and the mother is group O.

The Anti-A and Anti-B isoagglutinins in the mother's serum agglutinates the A,B, or AB cells of the prospective donor in the anti-human globulin crossmatch. Attempts to remove the isoagglutinins from the mother's serum by the addition of group specific A and B substance usually fails [3] because the immune isoagglutinins are not neutralized.[10] The problem is resolved by transfusing blood compatible with the baby [1,7,8,9] or by using group O Rh negative blood [1] compatible with the mother's blood [2]—the latter occurring more frequently.

Allen [2] stresses the necessity of crossmatching the donor's red cells with the serum of the baby's mother. Her serum has more Rh antibody than that of the baby and is better for detecting incompatible donors. Another advantage of using maternal serum for crossmatching blood for an exchange transfusion is that this can be done leisurely prior to delivery. Allen [2] further recommends that the blood crossmatched before birth, with maternal serum, be Group O, Rh negative [11] from a "non-dangerous O donor." He states further[2] that the blood of the baby's own type may be used if this blood group is compatible with the mother. The mother herself may be used for a donor if her plasma is removed and the cells resuspended in compatible plasma.

Most of these recommendations have been found confusing, and even dangerous in practice. Whenever the mother is group O and the baby is Group A or B, it is usually impossible to crossmatch group A or B Rh negative donor cells in the mother's serum. Attempts[3] to neutralize the Anti-A and Anti-B in the maternal plasma with AB substance, do not always succeed.[10] It is not practical, therefore, in 20 per cent of cases to use "Blood of the baby's own type, if this is also compatible with the mother."

*From the Community Blood Bank and Serum Service and St. Mary's Hospital, Hoboken, N. J.

The use of group O blood of a "non-dangerous O donor" for exchange transfusion in a group A,B, or AB infant is far from being non-dangerous. The addition of AB substance to the O blood does not make it safe.[3,10,14,15]

In ABO hemolytic disease of the newborn, it is advisable to transfuse group O blood into a group A or B baby[4] because the survival of O cells is greater than transfused group compatible cells.[5] Here, too, it is advisable to crossmatch the donor's cells in baby's serum, rather than in mother's serum,[3,6,9,10] because of the immune Anti-A and Anti-B in the mother's serum.

Not enough concern is given to the effect of the Anti-A and Anti-B agglutinins on the remainder of the baby's own red cells in exchange transfusion of O blood in a non-group O baby, in both Rh and ABO hemolytic disease.

The following recommendations were recently made by Mollison and Cutbush[5] for treatment of ABO hemolytic disease due to ABO incompatibility:

1. Transfuse with group O blood
2. Anti-A or Anti-B in group O plasma unimportant since most infant's own red cells will be removed by exchange transfusion
3. Remove plasma from Group O blood and give packed cells
4. Add AB substances to group O blood to diminish Anti-A and Anti-B
5. Remove plasma from group O blood and resuspend cells in AB plasma

There is complete agreement with recommendation number 1—to use group O blood for exchange transfusion in ABO incompatibility, since maternal immune Anti-A or Anti-B is the cause of hemolysis of the baby's red blood cells. However, the need for the use of group O blood does not hold in exchange transfusion for Rh hemolytic disease where maternal Rh antibodies, unrelated to blood groups, is the cause of hemolytic disease.

In the discussion of the second recommendation where Anti-A and Anti-B are considered not important because most of the infant's red blood cells are removed by exchange transfusion, it is advisable to consider the following facts. If 500 cubic centimeters of blood from a "dangerous group O donor" with an Anti-A titer of 1 to 500 are transfused into a normal size 70 kilogram group A adult, the final dilution of the Anti-A titer will be 38.5 units per cubic centimeter of plasma. If 500 cubic centimeters of blood from a "safe group O donor" with an Anti-A titer of 1 to 100 is exchanged transfused into a normal 3.5 kilogram infant, then the final dilution of the Anti-A titer will be 90 units per cubic centimeter of plasma. Since a transfusion of group O blood resulting in a final dilution of 38 units of Anti-A per cubic centimeter of plasma in an adult is considered dangerous, then a titer of Anti-A more than twice this strength in a newborn, jaundiced infant, surely should be condemned and avoided. This practice of exchange transfusing group A,B, or AB babies with group O blood becomes more reprehensible when it is shown that a large amount of transfused Anti-A or Anti-B, about 22,500 units, from a "safe group O donor" is placed in contact with a small mass of baby red blood cells—approximately 25 cubic centimeters. Contributing to the baby's cell mass which is incompatible with the transfused group O plasma, are new cells produced by the bone marrow of the baby. The resulting high concentration of antibodies in the presence of incompatible red blood cells can easily result in more hemolysis and increased bilirubinemia—the indications for the exchange transfusion itself. Often a second exchange transfusion is performed because of a rise in bilirubin, resulting in part from hemolysis during the first transfusion.

The third suggestion (to remove plasma and give packed cells) is inadvisable because of the tremendous disturbances in fluid, protein, and electrolyte balance and hematocrit would result in the newborn.

The fourth suggestion (to add AB substance to group O blood to diminish Anti-A and Anti-B for exchange transfusion) is not very helpful. The 10 cubic centimeter vial of AB substance decreases only the saline titer[11,12,13] approximately 75 per cent. It does not remove or neutralize the dangerous "immune antibodies." The added AB substance

itself, can result in sensitization since it is antigenic.[13]

The fifth recommendation (to remove the plasma from the group O blood and resuspend cells in compatible plasma) is cumbersome, but is the most advisable. The cells of the group O donor blood are usually well separated after standing 12 or more hours. If a large centrifuge (International No. 2) is available, centrifuge the 500 cubic centimeter bottle at 2000 revolutions per minute for 60 minutes. The plasma of the donor's blood can be removed by aspiration into a vacuum bottle. Plasma can then be aspirated by suction into the original bottle from a bottle of whole blood of a compatible group; that is, A or AB plasma for a Group A recipient. The plasma can be from a Rh positive donor.

The red blood cells of the mother of the erythroblastotic baby can always be safely used in an exchange transfusion in either Rh or ABO hemolytic disease. It is most important to remove as much of the plasma as possible from the mother's blood because the plasma contains the antibodies causing erythroblastosis.

SUMMARY

1. Exchange transfusion with group O blood should be avoided in group A,B, or AB babies with Rh hemolytic disease of the newborn.

2. When donor's cells are incompatible with mother's serum in Rh hemolytic disease of newborn, the same blood group as the baby should be used, and crossmatched against baby's serum.

3. When group O blood is exchanged transfused in other than group O babies, it is important to remove group O plasma and resuspend cells in compatible plasma.

4. In either Rh or ABO hemolytic disease of newborn, it is safe to use mother's red blood cells suspended in compatible plasma.

400 Willow Avenue

BIBLIOGRAPHY

1. Mollison, P. L.: Arch. Dis. Child., 18:161 (1943).

2. Allen, F. H. and Diamond, L. K.: *Erythroblastosis Fetalis*. Boston 1957. Little Brown, p. 54.

3. Shumway, C. N., Miller, G. and Young, L. E.: Pediatrics, 15:54 (Jan. 1955).

4. Mollison, P. L.: *Blood Transfusion in Clinical Medicine*. Ed. 2. Black Scient. Public. Oxford. p. 452 (1956).

5. Mollison, P. L. and Cutbush, M.: "Hemolytic Disease of Newborn Due to Fetal-Maternal ABO Incompatibility." Progress in Hematology. New York, 1959. Grune & Stratton, p. 153 (1959).

6. Wiener, A. S., Wexler, I. B. and Hurst, A. B.: *Blood* 4:1014 (Sept. 1949).

7. Wiener, A. S., Wexler, I. B. and Gamrin, E.: American Journal of Diseases of Children, 68:317 (Nov. 1944).

8. Wiener, A. S., Wexler, I. B. and Schulman, A.: American Journal of Clinical Pathology, 18:141 (Feb. 1948).

9. Wiener, A. S. and Wexler, I. B.: *Blood*, 4:1 (Jan. 1949).

10. Technical Methods and Procedures of American Association of Blood Banks. Minneapolis, 1956. Burgess Pub. Co. p. 43.

11. Witebsky, E., Klendshog, N. C. and Swanson, P.: Journal of the American Medical Association, 116:2654 (June 1941).

12. Blood Group Specific Substances A and B. Direction Circular, Merck Sharpe & Dohme M93410 (1960).

13. Kabat, E. A.: *Blood Group Substances*. Academic Press, Inc. N. Y. 1956. p. 298.

14. Ervin, D. M. and Young, L. E.: *Blood*, 5:61 (1950).

15. Ervin, D. M., Christian, R. M. and Young, L. E.: *Blood*, 5:553 (1950).

John H. Grindlay, M.D.

Rochester, Minn.

Surgical Research in 1960*

Comments Concerning its Place in Teaching and Practice of Surgery

Here is a plea to apply to research the same standards of equipment, personnel and technic that we apply to clinical surgery. Dr. Grindlay also sees the need for other scientists on the research team.

Surgical research is no different from other research. The beginning of a research problem is a question. The question may be: Is the accepted truth actually true?—or the question may be directed toward entirely new fields. Those who doubt and are inquisitive are better at research than those who accept blindly and without question. The question becomes a hypothesis. Experiments are planned and carried out to test the hypothesis. If the experiments fail, other hypotheses sooner or later arise and are put to the test. Certain hypotheses may properly be tested on human patients; in fact, only on human patients. But human beings can be used as subjects for experiment only to an extent I can best define as conforming to the ethical principle of the Golden Rule. The bulk of the experimental testing of hypotheses must be done on lower animals. Formerly this was called experimental surgery.

I have done little in the field of clinical surgical research, but I appreciate the value of the contributions made by others. I am aware, also, that "the proper study of mankind is man," and that conclusions drawn from experiments on lower animals have their validity finally tested by application to man.

It seems to me that surgical research is wanting in three respects: (1) many published reports are weak; (2) there is no organization to set standards for and test surgical materials; and (3) surgeons are too prone to delegate research problems.

PUBLICATION OF REPORTS

Many publications should include the phrase "A Preliminary Report" in their titles. Editors should accept such papers only with the understanding that the authors will later submit a paper based on long-term observations. Such a paper need not be long; a paragraph may suffice. I cannot prove my point, but I offer the guess that a third of such follow-up papers would be in the nature of retractions, in part or in full, or of qualification. This should be the policy of all professional journals. It would not deter those who write early reports purely from the Hippocratic desire to share knowledge with their professional colleagues. Do you recall enterogastrone? As far as one can tell from the

*Read May 18, 1960 before the Section on Surgery, The Medical Society of New Jersey, Annual Meeting in Atlantic City. Dr. Grindlay is from the Section of Surgical Research, Mayo Clinic and Mayo Foundation. The Mayo Foundation (Rochester, Minn.) is part of the Graduate School of the University of Minnesota.

literature, it is still a wonder drug for the treatment of duodenal ulcer.

It seems to me, also, that a great many papers have introductions which do not orient the reader and do not state the purpose and scope of the problem; the summary, too, is often worthless. Every summary should be an abstract describing what was done, how measurements were made, and what was observed.

And should we not try to couch our reports in the tongue that Shakespeare spoke? Surely it is not necessary to pollute the most richly descriptive language in the world with such tongue-twisting monstrosities, such etymological freaks of jargon, as are to be seen in some reports in our leading publications.

STANDARDS FOR SURGICAL MATERIALS

I MUST deal bluntly with the lack of standards for materials implanted in the human body by surgeons. It is fortunate that ethical manufacturers of surgical materials submit their products to rigorous tests, and that they maintain high standards of quality and uniformity. The only standards we doctors have are those stated in the *United States Pharmacopeia*. When I left medical school 25 years ago, the U.S.P., published every 10 years, and its adjunct, the *New and Nonofficial Remedies*, were adequate. Are they adequate now? How often do we consult the U.S.P. and N.N.R.? If we do look into them, to learn about standards for surgical sutures, for example, we will obtain antiquated information. Competitive manufacturers of silk and gut for sutures have standards far higher than those set forth in the U.S.P. Private and competitive industry have developed standards for surgical gut such that, for example, tetanus has not been attributed to "catgut" for about 25 years. In recent years, certainly, "silk" men and "gut" men have largely forgotten the old controversy. The silk of today is braided and treated with waxes and resins to make it "serum-proof"; it is a far cry from the twisted and easily broken silk of yesteryear.

Through no fault of theirs, investigators who write papers about uses of foreign materials, absorbable or permanent, are seldom able to describe the material scientifically. If the material is a synthetic resin (a polymer or plastic), the investigator and author is truly at a loss. The names "nylon," "teflon," "dacron," "ivalon," and so forth have no meaning. Manufacturers of such materials are competing in the industrial market. The names they give to their products mean little. For understandable reasons the trade-mark name is not changed when the structure of the polymer is changed. The plastics industry is devoted to what I might call the "throwaway market." The low price of the products enables the user to replace them easily when they break or wear out—or even when they have been used but once.

But we cannot blame the manufacturers. Suppliers and fabricators of basic materials have been cooperative and generous. However, neither they nor we know what is best for use in the chemical and physical environment of the body. None of us singly is at fault, nor are the manufacturers. "The fault, dear Brutus, is not in our stars," to quote Shakespeare, "But in ourselves, that we are underlings."

I know the trouble. We surgeons have "opera star" temperaments. What is white to Surgeon A will always be black to Surgeon B; collectively, *we* are at fault that we lack standards.

THE remedy suggests itself. Surgeons must, as protection for patients and as easement to their own consciences, know that materials they use have been tested, have met stated standards, and may be used under stated conditions. An organization for this purpose was recommended by the Joint Committee for Surgical Standards, a committee whose members represented the American Medical Association, the American College of Surgeons, the American Academy of Orthopaedic Surgery, and manufacturers of surgical materials and appliances. The committee was formed in 1952. Dr. Joseph Barr was instigator and chairman. His story about why he thought

surgeons and manufacturers should get together to form an organization for testing surgical materials and making certain they met standards remains the best illustration of the need for such an organization. The story concerned a surgeon who had just implanted an acrylic resin prosthesis in the hip of a patient. The surgeon had had two prostheses sterilized and made available for use. Just as the patient was being taken out of the operating room after the operation a nurse dropped the unused prosthesis on the floor. It broke. One can picture the feelings of the surgeon about his patient. He could only hope that the prosthesis he used was the proper acrylic polymer, and that after it had been machined into shape it had been properly annealed. The surgeon was not at fault; he could not know that "lucite" is only a generic name for acrylic resins, that the polymeric structure of some might be better than that of others which also are called "lucite," and that a particular acrylic polymer regains structural strength after machining only when it is heated to a certain temperature for a certain length of time. The Food and Drug Administration sets standards for what goes into our stomachs. Is it not strange that there are no standards for prostheses that are permanently implanted?

PARTICIPATION BY SURGEONS IN RESEARCH

ANY surgeon would take offense if he heard rumors that he was said to be a "cookbook" surgeon—so much of this ingredient, so much of that, mix, add a dash of flavor, and bake so many minutes. A qualified surgeon knows that if surgery were only a matter of following "cookbook" directions it could be done by trained butchers and seamstresses. One would think that a surgeon would shudder at the prospect of turning over the entire responsibility for an experimental study to men with no surgical training—the so-called basic scientists—although I do not wish for one moment to imply that they are butchers and seamstresses. True, the surgeon is busy and his first responsibility is to his patients. But if he intends having his name listed as one of the authors of a publication, he is personally responsible for carrying out the surgical procedures required for the study. He should make absolutely certain that any delegation of this responsibility is to none other than a trained surgeon.

I cannot agree that animal surgery can be done in any old laboratory, with nearly worn-out tools and equipment which surgeons would disdain to use in their operating rooms, with haphazard preparation and technic, and by untrained or insufficiently trained surgeons and assistants. One cannot have top-drawer standards for quality of one's work as a clinical surgeon, and accept "bottom-drawer" standards for research one sponsors.

Few problems in surgical research can be pursued entirely within the field of surgery. All problems require that results be measured. It is the rare surgeon who is qualified as a pathologist, physiologist, chemist, physicist, roentgenologist, endocrinologist—the list of such fields is forever lengthening. Casting innuendoes and implications aside, I shall say outrightly that when a project entails measurements which the surgeon is not qualified to make, such measurements should be made by a man qualified to do so. The cooperation of this trained scientist should be solicited at the outset of the experimental program. He should not merely be detailed at some convenient later date. The name of this scientific collaborator should be included as a co-author. If, however, in his opinion his share in the study does not merit co-authorship, then formal acknowledgment of his assistance must be made. Thus, authority is given to scientific details. To omit the name of this collaborator, or to fail to acknowledge his assistance, is ungentlemanly. Furthermore, this omission implies the masquerade of the surgeon as a quasi-scientist, thus suggesting that the study is of doubtful scientific value and exposing the author to ridicule. For example, his friends may know full well that he has but a child's knowledge of statistical analysis.

If we wish to learn the science of astronomy, do we seek instruction from an astrologer? Why then do we risk contamination of our neophytes by exposing them to the faulty technics of the nonsurgeon instructor? If I have persuaded you that experimental surgery, just as clinical surgery, should be undertaken by surgeons and that all training therein should be supervised by surgeons, then I have not wasted your time.

In conclusion, I might paraphrase Saint Paul: And now abideth these three: High quality of publications of research, standards for surgical materials based on tests, responsibility by surgeons for surgical research, and the greatest of these is . . .

But Paul was a saint, and no doubt had reasons for saying, nearly 2000 years ago, that Charity was greater than Faith or Hope. Since I have no immediate prospect of beatification, it would be invidious of me to draw a comparison regarding the relative importance of my three points. To my mind, each is equally important.

The Mayo Clinic

Surgery for Parkinsonism

Bertrand, Martinez and Gauthier (Canadian Medical Association Journal, 82:921, April 1960) summarize their experiences in the surgical treatment of paralysis agitans. Most of the 100 patients with Parkinson's disease were operated on in the following manner: with the help of a pneumotaxic guide, the center of the foramen of Munro was brought in line with the central ray of a standard craniograph. Stimulation and recording were then carried out at a point situated 10 mm. below and behind the center of the foramen of Munro at 15 mm. from the midline of the 3rd ventricle. A section was made with a fine wire leukotome placed immediately above and in front of the point for low voltage motor-face stimulation.

Such surgical lesions have produced marked improvement in more than 80 per cent of cases presenting tremor, rigidity, or akinesia. The remission obtained was doubtful in 5 per cent of the patients. Chief contraindications to the procedure are mental alterations or severe organic disease. Bilateral procedures should be used selectively and only in mentally alert patients. Patients are greatly helped by careful, well-localized surgical lesions. Harmful results from accurate sections are minimal.

Twins and Mental Illness

Neither schizophrenia nor psychiatric illness requiring hospitalization occurs more frequently in twins than in non-twins. This is the conclusion drawn by David Rosenthal, National Institute of Mental Health in the September Archives of General Psychiatry (1960). Dr. Rosenthal believes that the "confusion of ego identity" said to occur commonly among twins is not a causal factor in schizophrenia.

Figures based on studies in Sweden and Germany show that the frequency of twins in the population of schizophrenics is actually less than the estimated frequency of twins in the general population.

Some here said that twins are more likely to develop confusion of identity because they are dressed alike and treated alike and have more problems of sharing, especially of the mother, than their siblings. But, says Dr. Rosenthal if this were true, schizophrenia should occur more frequently among twins than among non-twins. Since this is not the case, the theory is doubtful. The author asked if the confusion of identity found among twins "is not something quite different from the confused identity found commonly in schizophrenics or in some preschizophrenics." He suggested that confusion of identity could be a symptom, rather than a cause, of schizophrenia.

WERNER KORNFELD, M.D., Ph.D.

East Orange

Developmental Aspects of Retardation*

Mental retardation is rarely a matter of a simple I. Q. defect. As Dr. Kornfeld here points out, it is often part of a large defect in development.

WHEN parents become aware—either by their own observation or by the findings of a physician—that their child is not progressing normally, they anxiously inquire about the outlook for the future. Their concern is not limited to the chances for the intellectual capacities of their child, even in cases of clearly predominant mental deficiency. Particularly if the retardation is detected in early infancy, the parents frequently show an even greater anxiety about other, more general facets of the child's development. They want to know whether the child will grow normally, whether he will look like a normal child, whether and when he may start to walk, and so on. Later they will look forward towards each little achievement along these lines. It is touching to see how gratefully they accept each small step of progress as a sign of hope. The physician in charge of a retarded child has to be well informed about the relations between different types of mental retardation on the one hand, normal and pathologic variations in other developmental features on the other.

LONGITUDINAL GROWTH

LET us start with a discussion of growth in *height* among mentally retarded children. There is severe growth retardation in children with congenital *thyroid deficiency*. The untreated athyreotic or severely hypothyreotic child becomes a typical dwarf, reaching at an age of 18 years the size of a normal one or two year old. This retardation in longitudinal growth is accessible to substitution treatment. Started early, and regularly continued, thyroid medication in proper dosage leads in most cases to normal or above-average body length. This feature of developmental pathology is the most hopeful and readily corrected of all abnormalities in the hypothyreotic child.

In *mongolism* there is a moderate retardation of longitudinal growth, rarely influenced by the manifold recommended therapeutic procedures. More severe growth retardation is found in some case of *microcephalic* idiocy and in some of the less frequent syndromes of multiple abnormalities as Hurler's syndrome (gargoylism or dysostosis multiplex), where stunted growth and mental retardation are combined with enlargement of liver and spleen, marked deformity of the spine and other severe typical abnormalities of the skeleton, ribs and extremities.

As a contrast to such combinations of growth retardation with mental deficiency, we have to be aware of developmental abnormalities, where defective physical growth is compatible with normal mental development. The pituitary dwarf shows, as a rule, normal mental progress and so do most cases of typical chondrodystrophy, children crippled by the Klippel-Feil syndrome, or by Morquio's disease. In such cases it is important to emphasize the

*Presented May 18, 1960 before the Section on Pediatrics, at the 194th Annual Meeting of The Medical Society of New Jersey, in Atlantic City, N. J.

good chances for intellectual and scholastic progress. These children need help to overcome their inferiority feelings. Consciousness of their physical handicaps and consequent withdrawal from companionship may otherwise damage their social adjustment to such a degree, that utilization of their mental capacities is limited and pseudo-retardation may result.

RETARDED MOTOR DEVELOPMENT

MANY cases of mild to moderate mental retardation without detectable organic pathology, especially if present in more than one member of the family, are considered as plain "minus-variants" in the distribution of intellectual endowment. These cases are classified as simple familial mental deficiency. We know that in a similar way short growth on the borderline of the normal variation spread is an inherited feature in some families. Sometimes individuals show a combination of such familial short growth with mild to moderate mental deficiency plus essential underweight. Hypoplastic children with mental retardation [1] may be classified as "multiple unspecific minus-variants." They have to be differentiated from cases where defective genetic endowment expresses itself in multiple deficiencies, but where it is combined with a specific organic pathologic condition. In such cases, defective physical development and mental deficiency may be associated, for instance, with congenital cardiac pathology. One case of this type may serve as an example.

A first child of normal and healthy parents was born at full term by spontaneous delivery. The only remarkable fact in the family history is that a first cousin died in infancy from congenital transposition of the great vessels with a small ventricular septal defect. Our patient was slightly cyanotic at birth, but regained normal coloring on the third day. No cardiac murmur could be detected. The heart did not appear enlarged on percussion or on x-ray. There was an enlargement of the thymus which receded after one x-ray treatment. A preauricular fibroma (rudimentary accessory auricle?) was partly removed by ligation. Very conspicuous was a loud laryngeal stridor, which later on was unsually persistent and is even now (at the age of 6) still present. Bronchoscopy revealed redundancy of mucosa of the arytenoids, which were sucked into the larynx on inspiration plus adductor paralysis of vocal cords related to cerebral involvement. He had a spina bifida occulta at the level of the third, fourth and fifth thoracic vertebrae. Slight cyanosis reappeared occasionally in the second week of life on the occasion of breath-holding spells, but later on no cyanosis could be observed.

At the age of 10 months a systolic murmur appeared which became more distinct during the next year. The child was seen by several cardiologists and the diagnosis was open ductus arteriosus. This was confirmed at operation at an age of 5 years. Neither before nor after the operation did the boy show any handicap or discomfort from his cardiac condition. However, from the first year of life on, there was a moderate retardation of the motor and mental development. The intellectual progress† continued rather steadily at a level of an I. Q. of 85 to 90. The child's movements were clumsy, without definite neurologic abnormality. Evaluation at a cerebral palsy center led to the classification as cerebral palsy of moderate degree and of athetoid type.

Since an age of two, the mother described incidents, occurring in intervals of about 3 months, in which he showed recurring vomiting or mucus spitting attacks, combined with abnormal sleepiness of varying duration. It is possible that these attacks were "psychomotor equivalents."

When he was 4 years old he was treated for meningitis at the Newark Babies' hospital. No deterioration followed this attack.

Electroencephalogram revealed normal sleep record for his age.

We see here a child with a multiplicity of congenital defects on the one side: spina bifida occulta, preauricular appendix, open ductus arteriosus. On the other side, we see manifestations grouped around some cerebral damage: mild cerebral palsy, mild mental retardation,† defective innervation of the larynx and attacks belonging possibly to the group of "epileptiform" manifestations.

Relations between mental retardation and motor development are manifold. The motor handicaps in cerebral palsy or in muscle dystrophy may interfere with the ability to express adequate response to stimuli. Such cases require careful study to distinguish between pseudo-retardation and cases in which cere-

1. Kornfeld, W.: Developmental Problems in Infants and Children. Journal of the Newark Beth Israel Hospital, 8:233 (October 1957).

†About 20 per cent of all chidren have intelligence quotients under 90—Editor.

bral palsy or some other abnormality of the neuromuscular apparatus may be combined with real primary mental retardation.

As a contrast, severe mental retardation on the basis of cerebral pathology, as in cerebral dysgenesis, may include as an essential feature the inability to develop normal progress in the command of motor functions.

Moderate mental retardation as seen in mongolism and in simple familial amentia is frequently accompanied by moderate delay of the acquisition of the motor achievements of early childhood, as sitting, standing, walking, climbing, and later on, control of the small hand muscles. The retardation of motor development in hypothyroids again reacts almost miraculously to adequate treatment.

Retardation of motor development in severe hydrocephalus may be due in part to the heavy weight of the head. If the general development is severely damaged by systemic disease, defective progress in motor functions may be a consequence of general weakness and handicapped responsiveness. It is often taken as "proof" of a nonexisting mental retardation.

NUTRITIONAL PROBLEMS

There is also a two-way relationship between mental retardation and nutritional problems. Severe cases of mental retardation may not respond adequately to normal feeding procedures. Feeding difficulties may be the first alarm symptoms in congenital hypothyroidism, where the patients react surprisingly well to therapy. By contrast, we know children with cerebral agenesis or dysgenesis who develop into complete idiocy, but who feed from the beginning excellently and are nutritionally perfect.

Interference with nutritional progress by organic disease is noted in marked degree in the Riley-Day syndrome (familial dysautonomia), where it leads to extreme weakness. In such and similar conditions, lack of responsiveness (due to weakness) may simulate mental retardation.

Development of elimination control may be accomplished in cases of mild or moderate mental deficiency at the appropriate age, while it may be delayed in others far beyond the normally expected period. There appears, however, no definite correlation between the degree of mental retardation and degree of training difficulties.

PERSONALITY DEVELOPMENT

Within the many types of mental retardation, different kinds of emotional response are distinguishable in infancy. The placid character of the mongoloid is typical from the beginning; it is a highly distinctive feature. It is an important factor in the loving acceptance of these children by the family. By contrast, the nearly permanent irritability of many children with perinatal cerebral trauma may be extremely annoying and will increase the difficulty of accepting such a child during the gradual revealing of the defective mental development. Well known is the severe disturbance in the personality development in postencephalitic children with and without mental retardation.

Children with congenital hypothyroidism react miraculously to treatment in terms of physical development. They often progress satisfactorily in intellectual development. But they may show the most stubborn resistance to treatment in terms of personality. I was able to follow many cases over periods of 10 to 15 years under steady, adequate treatment. We were usually pleased with growth, with appearance, and (frequently) even with their scholastic progress. But I cannot remember one single case, where there were not some deviations in behavior or in the shaping of their character. These disturbing features may appear in early childhood, as, for example, in the form of clowning; later on as the "show-off" type in teenagers; or there may remain an inability to fit into groups, in spite of a frequently burning desire for friendship and recognition.

Not only in the "successfully treated" hypothyroid, but also in many other types of men-

tal retardation, personality development offers increasing difficulties at the time of adolescence. Clashes within the emotional life of the young boy or girl are aggravated by limitations imposed upon the satisfaction of their drives. These limitations, they think, are more severe than those imposed on their more fortunate schoolmates. Frequently these clashes are the more violent, the nearer the adolescent's mentality is to the average level. Guidance through this significant phase of life is particularly important to prevent trouble arising out of conflicts between increasing vital drives and limitations imposed by the mores. Otherwise these personality difficulties may lead to antisocial and even criminal tendencies.

SUMMARY

Mental retardation may have four different types of relation to deviations in other spheres of developmental progress.

(1) Both may be caused by a common pathogenetic mechanism, as in certain inborn errors of metabolism such as galactosemia. These disorders interfere with physical and mental development. The same may be true in genetically determined multiple deviations; in mongolism as well as in gargoylism, mental deficiency and defective physical development are probably independent expressions of the same underlying pathogenetic mechanism.

(2) Mental retardation may be the effect of interference with the functions of the central nervous system by a developmental abnormality in another organ system: skeletal deformity in craniostenosis or faulty circulation of the cerebro-spinal fluid in hydrocephalus.

(3) Mental deficiency in itself may interfere with the development of motor achievements, elimination control, feeding procedures, emotional responsitivity or social adjustment. In these cases, the degree of the secondary handicaps may or may not parallel the degree of the mental deficiency.

(4) Mental retardation may be simulated by motor, sensor, or emotionally caused handicaps: pseudo-retardation.

The practical importance of knowing these relationships derives from the physician's need to be able to discuss with the parents chances and limitations for the child's future.

135 South Munn Avenue

Congenital Facial Diplegia

This report is concerned with seven patients who had congenital facial diplegia observed during the past two years. The condition is not as rare as might be deduced from the literature. The lower portion of the face is usually less affected than the upper part. This distinguishes it from the traumatic group, in which the upper and lower parts are equally involved. Four of the seven patients had bilateral paralysis of the abducens nerve, but this palsy had a distinctive character in that the patients were unable to abduct either eye beyond the mid-line and this was associated with paralysis of conjugate horizontal movement. The 12th cranial motor nerve was involved in three of the seven patients. Other abnormalities include clubfeet, pectoral-muscle and brachial deformities. One patient had bilateral equinovarus, another had syndactyly, and a third had valgus deformities of the great toes. Two had mental retardation. Immobility of the face, incomplete closure of eyelids when asleep, open mouth, and inability to suck are characteristic. The child fails to develop normal speech. An investigation of the antenatal histories revealed no evidence of infective, nutritional, or toxic factors. A genetic basis is postulated, and evidence is presented in favor of this theory.—M. Harrison, M.D., Medical Journal of Australia, 1:650 (April 1960).

G. A. Nitshe, Jr., M.D.

Monroeville

Simple Method for Aspiration of the Thoracic Cavity

The internist has to know more than how to write a prescription. There is even a field of manual skill.

Aspiration of fluid from the thoracic cavity is a frequently neglected procedure as can be attested by necropsy reports. The method outlined below will facilitate this modality.

An area of thoracic wall is properly prepared and draped. The site of aspiration is infiltrated with a local anesthetic. Disposable tubing with an affixed needle is inserted into an evacuated plasma container, with the tube first being suitably clamped so that the vacuum in the bottle is not lost. The sheath protecting the sterile needle is then removed and the needle inserted into the anesthetized area of chest wall. When the occlusion is removed from the tube, the vacuum will quickly withdraw fluid into the bottle. Should it be necessary to interrupt the procedure, or to add additional bottles, clamping the tube will prevent reflux of air into the pleural space.

The glass container with marked graduations permits constant observation of the quantity and physical characteristics of the fluid. As the equipment is sterile, optimum conditions are provided for the collection of specimens for bacteriologic or other examinations.

Burlington Road

SANFORD M. LEWIS, M.D.

Newark

Psychosomatic Factors in Constipation*

In these security-craving times the gastrointestinal tract is the prime sounding board of the emotions. Thus constipation, as Dr. Lewis says, is not so much a matter of treating a colon as of managing the man who surrounds that colon.

THE conventional introduction to a discussion of this nature might include an outline of Freud's formulation of the neurotic processes, both his early preoccupation with the id and libido [1] and the later amplification of ego psychology.[2] Modern gastroenterology is familiar with these concepts, however, and time is limited. It might suffice therefore, to presuppose the erection of a foundation for these remarks. This involves acknowledgment of the existence of the subconscious, understanding of the role of symbolism in human thought and behavior and acceptance of the interchangeability of feelings and physiology in the process of symptom formation.

Walter Cannon,[3] in the early 1900's, noticed that movements of the stomach and upper intestine ceased during strong emotion, while the sigmoid contracted to prevent feces from entering the rectum. He explained this as an economy of body function in the face of combat preparation. The observations are certainly valid, although we have learned somewhat more sophisticated explanations than his early "fright or flight" maxim.

During the 1940's, Almy [4] and his colleagues studied alterations in colonic function in patients under stress. In a series of healthy men, sustained contractions of the sigmoid were produced by a variety of unpleasant stimuli. This included, of all things, application of a head screw, induced hypoglycemia and discussions of stressful life situations. It was concluded that this hyperactivity was part of a general and normal adaptation to environmental changes regarded as threatening security. Gastric motility was reduced. Of greater interest, perhaps, is the fact that not pain but fear produced the reaction, since the colonic response to ice water immersion of the hand resulted only when the patient remained in doubt as to the safety of the procedure. Can we conclude at this point then that colonic spasm occurs in normal individuals where a significant threat to security exists?

The work was incomplete, however, since it was limited to normal volunteers. Accordingly, a group of patients with known spastic constipation was studied in similar manner.[5] Results were similar except perhaps in degree. The patient under stress, despite a reasonably favorable life situation, is in trouble because his neurosis causes him almost constantly to react to dangers that he alone per-

*Read at the Section on Gastroenterology, Annual Meeting of The Medical Society of New Jersey on May 18, 1960.

1. Freud, S.: Collected Papers, Volume I. The Defense Neuro-psychoses, Page 59, Basic Books, New York, 1959.
2. Freud, S.: Collected Papers, Volume 5. Splitting of the Ego in the Defense Process, New York, 1959. Basic Books, Page 372.
3. Cannon, W. B.: The Mechanical Factors of Digestion. International Medical Monographs. London, 1911. Edward Arnold & Co.
4. Almy, T. P., *et al.*: Gastroenterology, 3:425 (March 1949).
5. Almy, T. P., *et al.*: Gastroenterology, 3:437 (March 1949).

ceives in his environment. His attitudes stem from earlier determined subconscious drives. This is the substrate postulated at the beginning of this discussion. Stress is always present or at least repetitive, in individuals so constituted. So is constipation.

Perhaps most significant of all is the resemblance to the reaction in normals. Thus, since the colonic change in the so-called neurotic suffering with constipation is not qualitatively abnormal, it seems unlikely that continued treatment with drugs or diet will solve very much. Clinical experience bears this out. Environmental manipulation may offer temporary improvement. Usually an opportunity for working through the stress reaction in a psychotherapeutic climate is the only effective and more permanent means of altering the unfortunate status. It is not the colon which needs treatment but the man who surrounds it.

CERTAIN fundamental facts about the anatomy and physiology of the colon bear emphasis at this point. There are two distinct functional units. The first of these is the colon and rectum, controlled by the autonomic nervous system. The second is represented by the external anal sphincter which, after toilet training, is under voluntary control. With two distinct pathways leading from the central nervous system to these areas we may expect different dynamics to apply in their reaction patterns. This is so, and the psychoanalytic investigations of Alexander[6] help to tell us exactly why.

The hysterical conversion symptom, he reminds us, is an attempt to relieve emotional tension symbolically. "I want to kill you—instead my arm is paralyzed!" Obviously it must be restricted to the voluntary neuromuscular system. The anal sphincter is a charter member.

A vegetative neurosis, on the other hand, involves psychogenic dysfunction of a vegetative organ like the rest of the colon which is not under voluntary control. Assuming that symptoms such as colonic dysfunction express unconscious emotional striving or prohibition of such needs, and, that constipation connotes "retaining" or "hoarding," how can this active voluntary pattern apply to any part of the colon except the anal sphincter which enjoys voluntary control? Szasz[7] has pointed out that defecation in the infant is part of a hunger-nursing-excretion-sleep pattern. Stomach filling through the gastrocolic reflex, mediated by the vagus, leads to peristaltic movements in the colon and eventually expulsion. Defecation in the little child is certainly not a voluntary act, and differentiation of the role of the external sphincter occurs developmentally late. Eventually when brought into play, it serves an inhibitory function. Thus the child learns voluntarily when to prevent defecation, not when to perform the act.

If, then, the gastrocolic reflex is primary, perhaps colonic activity, at least the vegetative or involuntary part, is actually simply a mirror of the upper gastro-intestinal situation. It would thus change only in reactive fashion to the state of the stomach, and only the repressive function of the external sphincter would be a truly primary colonic phenomenon. Not alone food in the stomach but anticipation of food and further, anticipation of pleasure can accomplish the same result. We can, therefore, assume some such chain of events as this: hunger appeasement produces decreased vagal activity producing decreased stomach tone resulting in increased activity of the colon. Chronic psychic stimuli resulting in either sustained vagal activity or inhibition can produce chronic inactivity of the large bowel or continued spasm. There is a reciprocal effect.

Psychoanalytic studies show an accurate correlation between these phenomena and changes in the patient's unconscious oral incorporative drives. Acquisitive strivings, expressed physiologically by increased vagal tone, are associated with constipation, and sudden lapses in such direction, usually through guilt, predictably result in diarrhea. Thus a clearly defined

6. Alexander, F.: Psychosomatic Medicine, 5:205 (1943).

7. Szasz, T. S.: Oral Mechanisms in Constipation and Diarrhea. Paper at American Psychoanalytic Association Meeting, Detroit (April 28, 1950).

physiologic link has been established between emotional needs, their symbol or equivalent in terms of oral satisfaction, vagal tone and colonic activity. We are able to see that constipation within this formulation does not connote primary psychologic content. In other words it does not possess a symbolic meaning of its own. It is merely the result of a psychophysiologic change, the initial link of which is psychologic in meaning, the colonic response following willy-nilly.

WE HAVE our choice. We can accept the conventional psychoanalytic concept of symptom determination wherein constipation and diarrhea, for instance, have specific symbolic meaning. This is an attractive alternative, since we merely assume the psyche-physiologic bridge to exist, and leave it to the more organically-minded investigator of the future to discover its identity. On the other hand, we can embrace the less attractive but perhaps more experimentally documented idea that only voluntary nervous system and organs can respond consciously or unconsciously to specific ideas, whereas vegetative functions as represented by most of the colon, are merely prisoners of non-specificity and can manifest only reactive changes to primary effects elsewhere.

Fortunately we need not actually make the choice. Clinical investigation continues along both roads. In daily office and hospital experience, we see phenomena which might be explained only by one or the other concept. Perhaps the eventual resolution will lie somewhere in between.

The transition between experimental theory and practical clinical reality is sometimes difficult. Economies of time and of money make strictly limiting demands. Are there ways then of bringing into daily practice some of the dynamic principles which make up the basis of modern psychosomatic concepts? An illustrative case from the Psychosomatic Clinic of the Newark Presbyterian Hospital suggests that perhaps there are. The patient was seen in a single consultation session, forty-five minutes in duration.

The patient is a heavy, 59-year old married woman, of somewhat less than average intelligence. She is soft-spoken and pleasant, although easily moved to tears whenever sensitive areas are touched. She had been referred from the gastrointestinal clinic because of vague abdominal pain, obstinate constipation and variable levels of depression. A thorough study was essentially negative. Despite the fact that she is on tranquillizers, she says: "My nerves are so bad I blow my top, and then I get depressed. I can't sleep. I sometimes feel my husband ought to put me away where I can't hurt anyone." Two dominant themes involve her relationship with her husband and his alcoholism and, perhaps even more cogent, her failure to have children. Her husband used to drink heavily. She was then afraid to leave him alone. She could not even go out to work because he would immediately resume drinking. This situation apparently led to increasing constriction of her life outside the home to a point where she now has no friends, no social activity and does absolutely nothing except watch television. A poverty of inter-personal relationships is marked, and she reacts to a discussion of the situation by tears.

In her relationship with her husband, she is both masochistic and hostile. In the first place, she says: "He is so good; it's really not his fault. If he hits me it's because I pushed him first and it's all my doing." On the other hand (especially when he has taken a drink without her permission) she becomes furious, strikes him and quotes herself as saying, "I'll kill you." During these periods, constipation becomes more severe. The flare-ups of aggressive hostility apparently fill her with guilt, and once again she is encompassed by the resulting depression.

A foundation for this reaction of deep guilt in the presence of hostility, particularly her own, was provided in her early upbringing. She indicates, "My whole family was very nervous; we were brought up to fear things like lightning and the dark." She describes in detail protective measures her mother took whenever there was a storm or any other threatening situation. She, too, is moved to storm and thunder, particularly vis-a-vis her husband who (although she cannot verbalize this) has failed to give her children and who "cheats" on her, albeit only by the use of alcohol. Anger and hostility, however, are so much to be feared that guilt results, and she escapes by masochistically turning her feelings inward and hiding under the cloak of depression.

The depression is accentuated by her failure to have children. She has replaced babies with animals. There have been several such pets. In each case, their death produced mourning exactly as might be expected with the death of a child. The last pet was a parakeet whom she has not been able to replace since "I loved it so much and it hurt me so much that I do not want to go through this again." Significantly, she reports a dream in which she went to an amusement park and was strapped into a seat. She then became extremely fearful and begged to be released. When she asked for her money back, the man told her that she couldn't have cash but could take a prize. At this point, she saw a lovely little blue toy which hopped

around, and this delighted her. In discussing the dream, she makes a clear association between the little object and the parakeet which was lost. She is unable to verbalize the underlying need for a small love object, particularly a baby. The aggressive hostile elements of the first part of the dream are apparent.

In essence, then, we are dealing with a fairly severe depressive reaction predicated primarily on deprivation in terms of a needed love object, constriction and sterility of inter-personal relationships and great guilt provoked by her hostile reactions to the situation. There is also the element of her involutional status. The presenting symptom of constipation, waxing and waning as it does with the ebb and flow of depression or guilt, is apparently a secondary symptom. It occurs as a result of the over-all gastro-intestinal reaction to the emotional tide. From a therapeutic point of view, then, the emphasis is more properly placed on the psychiatric rather than the colonic reaction. Such a recommendation was accordingly made to the referring clinic. It was decided to try one of the newer anti-depressive drugs, in this case Nardil®, to attempt some environmental manipulation through social service facilities, and to de-emphasize the losing pharmacologic battle with a colon not really responsible for its own inadequacy.

CONCLUSIONS

As CLINICIANS we do not insist that we understand the pathogenesis of malignancy or rheumatic fever before we begin a therapeutic program. We do not argue that, since the nature of the atherosclerotic process is still highly theoretical, we can make no intelligent approach toward its control. It would be equally fallacious for us to take the not uncommon position that since psychiatric knowledge is still very deeply rooted in theory, it cannot contribute effectively to the comprehensive treatment of illness.

As physicians we ask of one another a thorough grounding in the intricacies of physiology, of radiologic anatomy and lately even of enzyme chemistry. It seems altogether reasonable then that we should extend every effort toward acquiring also a thorough orientation in psychodynamics.[8]

The path toward fully integrated and successful management of sick people lies not in a vague superficial acknowledgment of "psychogenic overlay," but in a true understanding of the important psychologic and physical factors operative in any given case. This is a psychosomatic approach with equal emphasis on both components. It has made contributions in many areas. Certainly the vexing problem of constipation is not the least of these.

---

8. Lewis, S.: A Formulation for Psychosomatic Practice. JOURNAL of The Medical Society of New Jersey, 55:662 (December 1958).

88 Chancellor Avenue

Ulcerative Colitis

Peskin and Davis, in *Surgery, Gynecology and Obstetrics* (110:269) report that a fulminating form of ulcerative colitis exists in which the colon becomes distended, mimicking closed-loop intestinal obstruction. Onset is abrupt. The attack may reach its peak in three weeks. It may continue for months and terminate fatally or resolve into a chronic stage.

Patients become acutely ill, with abdominal pain, diarrhea, vomiting, high fever and prostration. Accompanying this is abdominal distention, tenderness and diminished peristalsis. The proctoscope reveals an active process of ulcerative colitis.

In these cases the colon is merely a sac of pus, blood and feces and the usual medical therapy will not suffice. These patients are too sick not to be operated upon. Treatment of choice is a colectomy. With the removal of sepsis there is a dramatic and sudden improvement. Improvement after ileostomy is more gradual and recurrence is possible if inflamed colon is left behind.

ABRAHAM I. FRIEDMAN, M.D.

Hackensack

Small Bowel Biopsy*

Newer technics in small bowel biopsy open the door to remarkable possibilities in accurate diagnosis in the much neglected field of gastroenterology.

ROENTGENOLOGY has long been a facile form of investigation for diseases of the gastrointestinal tract and occupies the most prominent place in diagnosis. However, shortcomings with this modality in the examination of the gastrointestinal tract are more likely than in the roentgen examination of other systems. Non-specific changes may reflect organic disease or be an indication of a functional disorder. Endoscopic procedures, cytologic examinations, as well as chemical studies of the secretory function of the gastrointestinal system have been useful and important in increasing diagnostic accuracy. But there remains a substantial minority of cases where, in spite of all these technics, diagnosis is uncertain and, despite surgical exploration, a final opinion is sometimes equivocal or indefinite.

In 1948 Wood, in cooperation with Doig[1] developed an ingenious method for the procurement of a gastric biopsy. This consisted of a length of plastic tube with a small metal capsule at its distal end containing a knife blade that sweeps across a foramen and is activated by a rigid wire in the hands of the operator.

Shortly thereafter, Shiner[2] introduced a tube for obtaining duodenal and jejunal biopsies. In rapid succession there have been various modifications of the original Wood's tube, Rubin,[3] Crosby,[4] Carey *et al.*[5] The principle is essentially the same. By means of suction a small knuckle of mucosa is aspirated into a 3 or 4 millimeter aperture in a metal capsule and then either by means of a spring mechanism, a rigid wire, or further suction through the thin plastic tube the mucosa is sheared off. An adequate biopsy specimen is obtained and from as far down as distal ileum when necessary. The method is safe. No serious complications have been encountered although bleeding has been reported and the possibility of perforation in an atrophic mucosa must be borne in mind. The amount of suction must be gauged accurately and too vigorous use of the instrument is not encouraged. Recently an ingenious method of obtaining serial biopsies at different levels delivered to the operator in sequence by water transport has been devised by Rubin and his group.[6] The method may be hazardous. It is still too new to evaluate.

*From the Department of Gastroenterology, Division of Medicine, Bergen Pines County Hospital, Paramus, N. J.

1. Wood, I. J., Doig, R. K., Motteram, R., Weiden, S. and Moore, A.: Gastroenterology, 12:949 (1949).
2. Shiner, M.: Jejunal-Biopsy Tube. Lancet, 1:85 (1956).
3. Brandborg, L. L. *et al.*: Gastroenterology, 37:1 (1959).
4. Crosby, W. H. and Kugler, H. W.: American Journal of Digestive Diseases, 2:263 (1957).
5. Carey, J. B., Jr. and Pankey, G. A.: A Simplified Intestinal Biopsy Capsule. Read before A.G.A. Annual Meeting, April, 1960, New Orleans.
6. Flick, A. L., Quinton, W. E. and Rubin, C. E.: Hydraulic Biopsy Tube for External Delivery of Multiple Biopsies from Any Level of the Gastrointestinal Tract. Read before A.G.A. Annual Meeting, April, 1960, New Orleans.

What are the advantages of small bowel biopsy? Material for study of the mucosa and submucosa in diffuse lesions of the small bowel has been difficult to obtain. Autolysis quickly follows biopsy of the small bowel and has prevented meaningful analysis of autopsy material; surgical material at laparotomy has been the only source material. On the other hand, the peroral biopsy once obtained is rapidly removed from the instrument and fixed. The preservation of the finest details of the mucosa which are readily visualized with the ultramicroscope is a factor of time. *Less than one minute should elapse between the act of separating the tissue and placing it in the fixative.* A clarification of the diseases of the small bowel, a subject long neglected, full of misconception and premature opinion because of failure to obtain fresh pathologic material is now being oriented. Small bowel diseases, nutritional, genetic, inflammatory and malabsorption factors and a host of other lesser known conditions are open to study. The involvement of the small bowel in innumerable other nutritional and systemic diseases like Whipple's disease, portal cirrhosis, and so forth, can be accurately studied. The distinction between primary small intestinal disease and secondary involvement in systemic diseases can now be realized. The diagnosis, for example, of celiac disease and sprue (or as the latter is presently recognized—adult celiac disease) can be made by biopsy in the early stages when roentgen findings are non-specific or absent. The effect of the gluten-free diet on small bowel mucosa can be followed simply and accurately by small bowel biopsy. The amorphous group of diseases included in the malabsorption syndrome can now be classified and categorized. Similarly, early regional enteritis can now be diagnosed. Although small intestinal mucosa is adequately studied with the ordinary microscope, the ultramicroscope has opened vast fields of histo-chemical research. The small bowel biopsy is another instance where scientific methods of investigation appear in response to an appreciation of the clinical problem.

The most important utilization of this tool is in diffuse small bowel disease. Localized lesions like lymphosarcoma or carcinoma may be successfully biopsied but with induration or fibrosis there is less likelihood of obtaining adequate tissue for study.

405 State Street

Do You Ask About Social Life?

The author of *The Doctor,* Stanley R. Truman, comments in the October 1959 *World Wide Abstracts* that not one of a number of patients personally canvassed by him who had recently undergone examination by internists, had been asked about their social or emotional problems. This is not a complete examination and misses in a high percentage of patients. Today most general practitioners do basically internal medicine—the basis of all good medical care. In the future they will attempt to cover the common illnesses seen by the family and the public in general, and they will orient themselves toward the total patient.

Addiction is a City Disease

More drug addicts live in New York than any other state in the U. S., according to *Patterns of Disease,* a Parke, Davis & Company publication for the medical profession. Of the four states in which most of the nation's addicts are concentrated, New York is first with 45 per cent of total active addicts, Illinois second with 14 per cent, California next with 13 per cent and Michigan fourth with 5 per cent.

Addicts live mainly in big cities, *Patterns* states, and are found largely in the poorest areas of such cities, "characterized by lowest income, poorest housing, unstable family structures, and highest delinquency rates."

Trustees' Meeting: August 21, 1960

The Board of Trustees met in the Trenton office on August 21, 1960. Among the matters considered were:

Submission to the Governor of suggestions for the State Board of Medical Examiners. These names are based on a mail poll.

1. Vincent P. Butler, M.D., Jersey City
2. Marcus H. Greifinger, M.D., Newark
3. Joseph M. Keating, M.D., Passaic

Upon motion by Dr. Kaufman—seconded by Dr. Greifinger, and unanimously carried—the Board confirmed the nominations as submitted to the Governor.

BLUE CROSS DIAGNOSTIC RIDER

The President made a summary of developments since the July 5 meeting of the Boards of Medical-Surgical Plan and the Medical Society:

1. On July 7, the New Jersey Hospital Association adopted a resolution addressed to the Commissioner of Banking and Insurance stressing their determination to urge Blue Cross to issue a separate rider for diagnostic services.
2. On July 12, the President and Executive Committee, at a conference agreed that nothing could be done by the Medical Society at that time.
3. On July 26, the President and Executive Committee had another conference (joined by Dr. Donnelly and the members of the special committee) which determined that it "would be futile to hold the four-part conference to discuss the terms of an acceptable concurrent rider." The Executive Committee rejected Medical-Surgical Plan's recommendations for a special meeting of the House of Delegates to achieve approval of a "concurrent rider as the only feasible and practicable solution for the present situation."
4. On August 8, the Hospital Service Plan submitted to the Commissioner a proposed Blue Cross rider for diagnostic services. This would sell for half the cost of Blue Shield Rider "A" and would be available only to subscribers *not* holding Blue Shield Rider "A."
5. On August 11, the President asked the Commissioner to take no action on the Blue Cross rider until a hearing was granted to representatives of the Medical Society to discuss with the Commissioner "all the implications and consequences of such Hospital Service Plan rider" and "the reasons The Medical Society of New Jersey opposes such rider."
6. On August 15, the Commissioner replied that no action on the Blue Cross rider would be taken until after September 1, at which time representatives from the Medical Society would present the Society's position.

Prolonged and protracted discussion followed, covering all aspects of the matter. Dr. Alfano presented his views as to what would be the impact of the issuance of such a Blue Cross rider upon the sale of Blue Shield Rider "A."

The Board approved continuance of the present policy and action with regard to the concurrent rider; and also approved continued activation of the special committee (of which Dr. Donnelly is chairman) before the State Commissioner of Banking and Insurance to oppose the issuance of a separate Blue Cross rider for diagnostic services.

The Board took this occasion to confirm the reappointment of Dr. Donnelly and his special committee "to wait upon the Commissioner of Banking and Insurance for the purpose of opposing a separate Blue Cross rider for diagnostic services."

The Board then adopted a recommendation, to be submitted to Medical-Surgical Plan, that Medical-Surgical Plan of New Jersey investigate the possibility of bringing its Rider "A" premium rates in line with those of the Hospital Service Plan, based on a study of all claims and rates.

STATE HEALTH DEPARTMENT

The Division of Chronic Illness Control of the State Department of Health is co-sponsoring, with the Department of Institutions and Agencies, its second symposium on electroencephalography on November 2. The Medical Society co-sponsored the symposium last year and is requested again "to support and endorse by co-sponsorship" this educational program. The Board voted to co-sponsor the symposium.

REPORT OF A.M.A. DELEGATES

Prior to the meeting, all Board members received a copy of the report of the chairman of our A.M.A. delegation. See page 661.

Upon motion by Dr. Allman—seconded by Dr. Greifinger, and unanimously carried—the Board approved the report as distributed, with the following addendum: "The Medical Society of New Jersey and the chairman of the delegation were honored by the election of the latter to the office of vice-president of the American Medical Association."

COUNCIL ON LEGISLATION

The chairman of the Council on Legislation presented a report of the actions taken by the council at its meeting on July 27, 1960. See page 662.

Upon motion by Dr. Greifinger—seconded by Dr. Kaufman, and unanimously carried—the Board approved the report and adopted all the recommendations contained therein, with the following exception:

1. *Liability Insurance for State, County and Municipal Employees*

Upon motion by Dr. Hughes—seconded by Dr. Ware, and unanimously carried—action on item No. 1 was deferred, at the request of Legal Counsel, until the September meeting, for purposes of consultation between the Legislative Analyst and Legal Counsel.

CIVIL DEFENSE

On September 21 and 22 the United States Civil Defense Council will hold its conference in Minnesota. This year emphasis will be placed on medical and public health needs for non-military defense.

Upon motion by Dr. Ware—seconded by Dr. Collins, and unanimously carried—the Board authorized R. Winfield Betts, M.D., Chairman of the Special Committee on Disaster Medical Services, to represent the Medical Society at this conference, with expenses paid.

A.M.A. PUBLIC RELATIONS INSTITUTE

The American Medical Association is sponsoring its annual Public Relations Institute, "As Others See Us," in September 1960.

Upon motion by Dr. Greifinger—seconded by Dr. Ware, and unanimously carried—the Board authorized the Executive Officer and the chairman of the Council on Public Relations to represent the Society at this conference, with expenses paid.

HEALTH CAREER SERVICES

The Board authorized a contribution of $100 to the New Jersey Health Career Services in support of its vocational guidance activities.

TRANSFER OF FUNDS

The Treasurer requested the Board's permission to transfer $30,000 from general funds to savings accounts in three different banks: $10,000 each in Asbury Park-Manasquan Bank, First National Bank of Camden, and First National Bank of Westville.

Upon motion by Dr. Greifinger—seconded by Dr. Kaufman, and unanimously carried—the Board approved the transfer of funds in the amount of $30,000, with the recommendation that any further investment be made in savings banks.

Report of A.M.A. Delegates

The Annual Meeting of the A.M.A. House of Delegates was a somewhat subdued session. There was some disappointment expressed due to the fact that the attendance was below that anticipated. This may have been influenced by the air pilots' strike, but many members expressed the opinion that June was not the proper season for a Miami convention. Another comment was that a great deal of time was taken up in emphasizing past activities and in efforts to better interpret previous resolutions.

The Sunday conference of the Presidents and Secretaries was highlighted by addresses by Paul Butler and Senator Morton, Chairmen of the National Democratic and Republican Committees respectively. Mr. Butler was very critical of organized medicine for its attitude toward the Forand Bill, which he favored. He stated that neither the A.M.A. nor

the private insurance system has presented a workable plan for care of the aged. He further stated that civil rights and care of the aged will be the biggest items in the Presidential campaign and further blamed the A.M.A. for the "scandal" over the drug price investigation. Senator Morton strongly advocated support of the Mills Bill to provide care for those aged unable to care for themselves.

During the session the Reference Committee which considered the report of the Board of Trustees on this subject presented the following report which was approved.

> Personal medical care is primarily the responsibility of the individual. When he is unable to provide this care for himself, the responsibility should properly pass to his family, the community, the county, the state; and only when all these fail, to the federal government—and then only in conjunction with the other levels of government, in the above order. The determination of medical need should be made by a physician, and the determination of eligibility should be made at the local level with local administration and control. The principle of freedom of choice should be preserved. The use of tax funds under the above conditions to pay for such care, whether through the purchase of health insurance or by direct payment, provided local option is assured, is inherent in this concept and is not inconsistent with previous actions of the House of Delegates of the American Medical Association

Dr. Louis Orr, in his Presidential address, stressed this point also.

The possibility of an increase in A.M.A. dues was discussed, but the Reference Committee suggested that this be referred to the Board of Trustees to review the programs of the A.M.A. with the idea of initiating economies which could make this increase unnecessary.

There was considerable discussion as to place of the 1963-64-65 meetings. New York was insistent on securing the 1963 session because of the Exposition being held there. This would have dislocated the regular sequence of meeting places, especially affecting New Jersey. With help from several states, especially California, the final decision was New Jersey 1963, California 1964, and New York 1965.

The action taken on the New Jersey resolutions were well reported in the July *News Letter* and do not need repetition. Your Delegation wishes to extend its appreciation to Dr. Henry Brodkin, who appeared with excellent informative material on Resolution 21 in reference to Aero-Medical Transport Service. This resolution was favorably received and approved.

All session of the House were attended by the full complement of Delegates. The conduct of the New Jersey Headquarters was well organized and operated, in accordance with the policy established by your Board. This is an improvement over the system when the Chairman of the Delegates had this responsibility, and we recommend its continuance.

The presence and assistance of our Executive Officer was most helpful to our Delegates, and we wish to express our appreciation for his contributions.

WILLIAM F. COSTELLO, M.D.

CHAIRMAN

ADDENDUM

The Medical Society of New Jersey and the chairman of the delegation were honored by the election of the latter to the office of vice-president of the American Medical Association.

Council on Legislation

1. *Liability Insurance for State, County and Municipal Employees.* The Legislative Analyst assured the council that adequate protection is afforded state, county and municipal employees in the case of suits filed *against them* for injuries sustained by others for whom they rendered direct and/or professional services in the course of their employment. This assurance is based on: (a) court decision and (b) declaration of the Attorney General.

> *Recommendation*: That the Board of Trustees authorize the publication of the summary report of the Legislative Analyst in THE JOURNAL for the information of the membership. *Action deferred* until September Board meeting.

A-22 *Flynn*—To remove ophthalmic technicians from the provision of the Ophthalmic Acts; amends Chapter 336, P.L. 1952. *Disapproval, with active opposition if bill moves.* It would weaken the present law and impair the protection afforded the general public without accomplishing any appreciable substitute benefit.

A-37 *Savino*—To provide that Milton H. Teitel, residing in Springfield, Massachusetts, shall be licensed to practice medicine and surgery in this state by the State Board of Medical Examiners without examination. *Active opposition.* It would circumvent the lawful procedure for the licensing of a physician adopted by the State of New Jersey as a means of protecting the public against unqualified practitioners. It is contrary to the public interest and unfair to physicians legitimately licensed by the State through the Board of Medical Examiners.

A-49 *Werner, Meloni*—To amend the act regulating nursing; reduces the age for professional nurse candidates from 20 years to 18 years and raises fees for examination and registration. *Approved.*

A-60 *Sweeney*—To eliminate requirements that a corporate trust shall be approved by a recognized medical society and 51 per cent of the licensed physicians in any county must participate before the corporation may transact business therein. *Active opposition.* It would eliminate the requirements originally insisted upon by the State Commissioner of Banking and Insurance which serve as a guarantee of the quality and adequacy of available medical care for subscribers under the contemplated plans.

S-209 *Jones, Ridolfi*—To provide certain group medical expense insurance benefits for state officers and employees; creates a health insurance board. *Approval.*

S-213 *Cowgill*—To prescribe the powers of coroners in counties other than first-class in which there is a county physician, but which has no chief medical examiners. *Disapproval.* The Medical Society of New Jersey in common with professional medical groups across the country has long been working toward the elimination of the coroner system, which makes possible the assignment of the office of coroner to a lay-individual whose qualifications are not sufficient in the area of science necessary to fulfill the duties of the office. Instead, it is the conviction of The Medical Society of New Jersey that the duties exercised by coroners should be assigned to county physicians or medical examiners.

Recommendation: That a letter be sent to Governor Meyner as well as to members of the Legislature expressing grave concern over this situation.

A-670 *Keegan, Kordja*—To provide for hospital, medical, and surgical expense insurance for state employees. *Disapproval.* It would empower the state to render conclusive determination as to whether the services rendered or the expenses incurred are eligible for payment under this plan.

ACR-43 *Sweeney, Farrington, Panaro*—To memorialize Congress to enact legislation providing hospital, surgical, and nursing home benefits to old age and survivors insurance recipients. *Disapproval.* It is economically unsound, politically unwise, and socially unjust to call upon the general citizens to pay for services which individual citizens are capable of providing for themselves. It is the contention of The Medical Society of New Jersey that only needed services which individuals and their families cannot provide or pay for should be made available through tax-supported programs.

Recommendation: That the listed positions on the foregoing bills be approved.

A-612 *D'Aloia*—Companion bill to A-611; concerns medical service corporations.

Previous approved position was to take no action unless or until MSP takes a positive stand and requests support by the Medical Society. Now MSP has outlined its opposition to A-612 and requested the cooperation of the Medical Society in support of that position.

Recommendation: In support of the position of MSP, that the position of the Society on A-612 be one of *Disapproval, with active opposition if bill moves.*

A-555 *D'Aloia, McGowan, Wilson*—To establish procedures for trustees, including six public trustees, for hospital service corporations having more than 1,000,000 persons eligible for service.

Previous approved position was to take no action unless and until the New Jersey Hospital Association requests support of its position by the Medical Society. The Board authorized the So-

ciety's support of the Hospital Association's opposition to the bill if and when a request for such support was received. Now, the Hospital Association has outlined its opposition to A-555 and requested the cooperation of the Medical Society in support of that position.

Recommendation: In support of the position of the Hospital Association, that the position of the Society on A-555 be one of disapproval.

H. R. 7966—To amend the definition of "medical services" to include services of optometrists.

The council was directed by the Board to "protest vigorously to the New Jersey members of Congress the enactment of H.R. 7966." However, this legislation has passed both houses of Congress and is currently awaiting the Presiden't signature.

AMENDMENT TO SCHOOL EXAMINATION LAW

In accordance with the directives of the House of Delegates, the amending legislation will be introduced into the 1960 Legislature as soon as possible. Senator Ridolfi, Mercer County, will again be requested to introduce this legislation. He has already expressed a willingness to do so.

SERVICES BY NON-PROFESSIONAL PERSONNEL

In accordance with the directives of the House of Delegates and the Board of Trustees, amending legislation to the Medical Practice Act (Section 45:9-21, Revised Statutes) will be introduced as soon as a suitable sponsor can be decided upon.

JUDICIAL COUNCIL OR COMMITTEE RECORDS

Resolution adopted by the House of Delegates that legislation be introduced soliciting confidentiality for Judicial Council or Committee records.

The council concurred with the Legislative Analyst in the opinion that to introduce such legislation would be futile, in view of the position taken consistently by the Legislature refusing privileged communication to physicians. It might only serve to generate bad public relations by seeming to introduce legislation with purely selfish motives.

Recommendation: That the Legislative Analyst, the Society's Legal Counsel, and the Executive Officer agree on some standard operating procedure for the judicial mechanism which would achieve the same end as the legislation.

The council points out, however, that this recommendation would not include immunity from service or subpoena of members of the Judicial Council and county society judicial committees.

INTRODUCTION OF LEGISLATION

The Council noted with concern the increasing tendency of the House of Delegates to call for the mandatory introduction of legislation by The Medical Society of New Jersey which, when all the facts are known, may not be in the best interest of organized medicine or may be completely unwise or impossible. Such situations prove not only embarrassing to the Council on Legislation and the Society as a whole, but endanger its position before the Legislature and the general public.

The Council recalled that, on January 4, 1953—at the recommendation of the then Subcommittee on Legislation—the Board of Trustees adopted the following policy:

In consequence of an extended analysis of the technical difficulties involved in the preparation and presentation of sound legislation, and upon the advice of legislative counsel, all committees and agencies of The Medical Society of New Jersey wishing to present legislation for enactment formally notify the subcommittee and supply it with the necessary material at least six months—and preferably nine months—in advance of the beginning of the next legislative year.

The Council strongly reaffirmed this policy.

Recommendation: That the Board of Trustees reaffirm its action of January 4, 1953, and that the entire membership be reminded of this policy; and in conjunction therewith, an operational procedure be initiated whereby resolutions for presentation to the House of Delegates recommending the introduction of legislation on the part of The Medical Society of New Jersey be submitted to the Executive Offices at least one month in advance of the annual meeting at which they are to be acted upon, with the understanding that, if approved, legislation will not be introduced until the following legislative year.

Cardiac Patient Wanted by FBI

John Edgar Findlay, with aliases of John Edgar Findley, Jack Findlay, John O'Brien, John Reed, Joseph Reilly, Big Jack, Jackson, Big Boy, Mr. Kellogg, is wanted by the Federal Bureau of Investigation for theft from interstate shipment and for fleeing New Jersey to avoid prosecution for murder. Findlay is charged with the theft of a load of cigarettes moving in interstate commerce, and with the gangland murder in New Jersey of Joseph E. Barbito. He is wanted as a material witness in the murder of two other men, and has been a fugitive since 1958.

Findlay began his criminal career in 1928 and was convicted of robbery in New Jersey for which he was sentenced to five years' imprisonment. Since then he has been convicted of robbery, passing counterfeit money, receiving stolen goods and mail theft. He has spent several years in prison. He was born in New Jersey and lived all his life in the New Jersey-New York Metropolitan area. He has worked as a musician, plumber, laborer, dock hand and pier checker.

In the summer of 1955, he had a "heart attack" from which he has reportedly suffered since. At times he has difficulty breathing and cannot walk any considerable distance without resting. He is known to use digitalis for this condition.

He lived in downtown Brooklyn during the autumn of 1958. It has been reported that he has had an operation for either "ulcers" or "heart trouble" during 1959 in the New York area under an assumed name. He has reportedly been obtaining medical attention from some doctors in the New York area.

Findlay is known to have been armed and should be considered extremely dangerous.

Any person having information which might assist in locating this fugitive is requested immediately to inform the Director of the Federal Bureau of Investigation, United States Department of Justice, Washington, D. C., or the Special Agent in Charge of the nearest Federal Bureau of Investigation Division, the telephone number of which office is listed on the first page of your local telephone directory.

New FACS Names for New Jersey

The American College of Surgeons announces that the following were made Fellows at the 1960 Convocation:

ASBURY PARK
Morris S. Weiss
George T. Whittle

ATLANTIC CITY
Morton A. Rosenblatt
Allan R. Shuster

BRIDGETON
Jesse W. Carll IV
George H. Huston III

CAMDEN
Howard D. Easling
Stanley J. Okulicz

CAPE MAY COURT HOUSE
G. Raymond Brown, Jr.

EAST ORANGE
Jack August
Thomas V. Judge

ELIZABETH
Warren H. Knauer

ENGLEWOOD
Willard H. Somers

FORT DIX
Adolphe J. Schoepflin

HADDONFIELD
Earl B. Keller, Jr.

JERSEY CITY
Julius J. Baber
Jerome A. Dolan
F. Peter Nicholson
Martin H. Perle

LONG BRANCH
N. Craig Roberts
Charles L. Zukaukas

MILLBURN
Harry A. Lotman

NEWARK
Lawrence F. Burnett
Franklin J. Mascia

NEW BRUNSWICK
Michael Brody
Thomas M. Heslin

PASSAIC
David M. Niceberg
Marvin P. Rosenberg

PENNS GROVE
John A. Surmonte

PERTH AMBOY
Howard D. Slobodien

POINT PLEASANT
Robert A. Ballou

PRINCETON
Charles H. Place

RAHWAY
Manley C. Williams

RED BANK
Daniel J. Collinson
Ernest Stich
Daniel M. Winters

ROCKAWAY
John J. Dudasik

SALEM
Loring E. Sylvester

SHORT HILLS
John J. Hudock

TEANECK
J. Richard Mazzara

TRENTON
Louis G. Fares
Edward L. Zega

UPPER MONTCLAIR
John J. Siudmak

Announcements • • •

Tumors of the Central Nervous System

The New Jersey Society of Pathologists, with the New Jersey State Department of Health cooperating, will hold its Tenth Slide Seminar on December 3, 1960, at the Essex House in Newark at 2:00 p.m.

The Moderator will be Dr. Abner Wolf, Division of Neuropathology, College of Physicians and Surgeons, Columbia University.

The slides and case histories have been mailed out. These cover interesting tumors of the central nervous system. As usual, many out-of-state pathologists will attend and all physicians are invited.

The Annual Seminar dinner will follow the meeting at the Essex House. You are invited to both. For further details, call Dr. Murray Shulman, at 913 South 20th St., Newark.

Seminar on Vascular Surgery

Wednesday, November 30, has been set aside for an afternoon colloquium on peripheral vascular surgery. Sponsored by the New Jersey Academy of Medicine, the seminar will be held at the Essex House, Lincoln Park, Newark, starting at 2 p.m. and terminating at 9 p.m. A star-studded faculty will discuss every aspect of modern vascular surgery between 2 and 5 p.m. A panel discussion is scheduled for the evening. The symposium is made possible by the Pfizer Fund for Graduate Education. For full program, write to Dr. Milton Shoshkes, 505 Elizabeth Avenue, Newark 8, N. J.

Do You Have an Exhibit for 1961?

The 195th Annual Meeting of The Medical Society of New Jersey will be held at Haddon Hall, Atlantic City, May 13 to 17, 1961.

Applications for space in the Scientific Exhibits gallery will be accepted by the Committee up to and including December 1, 1960. Notification of committee action will be made soon thereafter.

Forms may be obtained from the Executive Offices (telephone EXport 4-3154) P.O. Box 904, Trenton 5, N. J.; or visit 315 West State Street, Trenton.

Members are invited to apply for space in the Scientific Exhibits and are urged to obtain, complete, and submit applications early.

New Jersey Surgeons Meet

The New Jersey Chapter of the American College of Surgeons will holds its annual clinical meeting on Saturday, December 3, at Cherry Hill Inn, Haddonfield, N. J. The morning will be devoted to "wet clinics" and the afternoon will include an address by a distinguished surgeon. At 3 o'clock there will be round tables on various sub-specialties within surgery, including ophthalmology, traumatic surgery, and vascular surgery. Full details may be obtained by writing to Dr. Eugene H. Kain, 405 Cooper St., Camden 2.

County Society Reports • • •

Camden

The general meeting of the *Camden County Medical Society* was called to order at 9 p.m. on October 4, in the Independence Room of the Cherry Hill Inn by President Ornaf. There were 67 members present.

Drs. George T. Hare, Vojslav Mitrovic, Heldi Rink and Peter W. Vanace were introduced as Associate Members upon taking the oath and signing the register. Drs. Otto T. Boysen and Irvin Morgenroth were introduced as Active Members.

The applications of Drs. John H. Osler, III, for Associate membership, and Burton C. Dyson for Active membership were presented for first reading and referred to the Board of Censors.

Dr. William Most spoke of the programs for the year and introduced an informative film on the complete physical examination for cancer detection. Following the showing of the film, Dr. Leonard W. Parkhurst, Medical Director of the Benjamin Franklin Clinic of the Pennsylvania Hospital, discussed their method of physical examination and the conclusions drawn from these examinations.

Dr. Ornaf reported for the Executive Committee, outlining the steps leading to the sale of the building at 725 Federal Street, Camden, the final commitments and the discussions concerning location and appointments for new executive quarters. He then reported on the discussion in the Executive Committee regarding disposal of pictures, books, busts, and ornaments, indicating the availability of these items to any individual member of the Society. The Executive Committee has decided to engage an answering service at our new offices. The Committee polled the Society on the sale of the building. Final count was 258 affirmative and 5 negative votes.

A resolution covering the sale of the building was seconded and unanimously passed.

The names of the following were presented for balloting: Active membership—Drs. Leo L. Sell; Associate membership—Nicholas Karayannis, Nahum M. Baoltin, Norman N. Kohn, Robert C. Lesher, John R. McDermit, Ludwig E. Schlitt, and Howard F. Shivers, Jr. All were elected to membership.

Dr. Pratt was authorized to have 500 copies of the new By-Laws printed.

Dr. Palmisano raised the question of separate phone listing of members of the Society. Dr. Ornaf advised that this was under investigation and that we are hoping to accomplish this in time for the next telephone directory.

The meeting adjourned at 11:05 p.m.

FREDERICK W. DURHAM, M.D.

Reporter

Cumberland

The *Cumberland County Medical Society held* its fall meeting at Rainbow Lake on October 11 at 2:30 p.m. The meeting was called to order by the President, Alfred O. Davies, M.D., of Millville. There were forty-two members present.

Nicholas E. Marchione of Vineland, gave an enlightening report for the Legislative Committee. Dr. Marchione also discussed and clarified the Relative Value Scales, which was given approval by the members.

It was reported that the Student Loan Fund had made grants to 28 students throughout the state during the past year. One Cumberland County student was included.

Samuel B. Pole, of Bridgeton, chairman of the Conservation of Vision Committee, presented the findings of Conservation of Vision Week during which the public was invited to have free eye examinations in an effort to find latent eye pathology. Clinics were held at Newcomb Hospital, Vineland, under L. E. Rosiello, M.D. and at Bridgeton Hospital under the chairman. At Vineland 60 were examined and 10 were found to have eye disease; at Bridgeton 122 patients were examined and there were 40 with defective vision or eye pathology.

George T. Varga, M.D., of Bridgeton was appointed to head the Annual Diabetes Detection Drive.

John J. Pastore, M.D., of Vineland and Ronald M. Fisher, M.D., of Bridgeton, were welcomed to the Society as Associate members.

Guest speaker of the day was J. Gershon Cohen, Director of Radiology, Einstein Hospital, Assistant Professor of Radiology, University of Pennsylvania. Dr. Cohen gave a lecture on cancer research, explaining the studies on viruses, now considered the prime etiologic factor of that disease.

The meeting was adjourned at 5:15 p.m. for the enjoyment of a delicious dinner.

LEONARD G. SCOTT, M.D.

Reporter

Hudson

With Dr. Nathan J. Plavin, President-elect in the chair, the first regular 1960-61 meeting of the *Hudson County Medical Society* was held at Jersey City Medical Center on October 4. Principal speaker of the evening was Mr. William Braun, Attorney for the American Mutual Liability Insurance Company. Mr. Braun's subject was "What Can the

Medical Profession Do to Curtail Malpractice Claims?" Many members participated in a discussion from the floor.

Dr. Plavin announced that the Dinner-Dance of the Society would be held on April 22, 1961 at the Hotel Essex House in Newark.

Drs. Joseph Berke and Joseph M. Foley of Jersey City were elected to regular Active membership and Dr. Darwin A. Leuzzi of Union City was reinstated to regular Active membership. Drs. Anthony P. Lucci, Juan A. Mendoza, William A. Miles, Nellie Mitchell, and Frantisek Trunecka of Jersey City and Dr. Friedrich Karl Racke of North Bergen were elected to Associate membership.

It was announced that there will be a Graduate Seminar in Arthritis and Related Diseases on November 4 and 5 at Murdoch Hall, Jersey City Medical Center.

Following the business meeting, a collation was served

LOUIS KOSMINSKY, M.D.

Reporter

Monmouth

Dr. Lester Barnett opened the September meeting of *Monmouth County Medical Society* at Fitkin Memorial Hospital on September 28, at 9:15 p.m.

Dr. John F. Stockfisch, program chairman, introduced the speaker, Dr. Louis Amdur of Jersey City, a member of the Council on Medical Services of The Medical Society of New Jersey. Dr. Amdur explained the proposed "New Jersey Relative Value Index," which was presented to the House of Delegates of The Medical Society of New Jersey at its 1960 Annual Meeting.

A spirited discussion followed the talk. Some members felt the relative values were equitable; and others they were not. Dr. Gerald Whalen of Red Bank opposed the basic principle of a Relative Value Index. He suggested that this idea was being forced upon physicians because of third party payments. He said that the contract is between the patient and the physician; and that if we follow the RVI, we become "tools of the insurance industry." He stated that the RVI is based on the complexity of a procedure yet this may vary considerably from patient to patient depending upon the medical risk and the social status of the patient. Dr. Whalen expressed concern that the ultimate use of the RVI might be to chastise the physician for what seemed to be an unreasonably high fee; but when it came to defending an individual physician's fee, the insurance companies might choose to ignore the RVI.

Elected to Active membership were Drs. Nathaniel B. Cole, Elberon and Martin N. Malachowsky, Long Branch. Elected to Associate membership were Ignazio Dell'Aira, Hazlet; Laurence A. Donahue, Red Bank, and Gifford Grimm, Neptune.

LEONARD S. DANZIG, M.D.

Reporter

Salem

Dr. Carl Ware, First Vice-President of The Medical Society of New Jersey, was guest speaker as the *Salem County Medical Society* opened its season at the DuPont-Penns Grove Country Club on September 16, with the president, Dr. Ford C. Spangler, in charge.

Following committee reports, Dr. George A. Nitshe, Jr., immediate past president of the Society, introduced as his guest, Captain Edwin Kellerman, MC. Captain Kellerman, a native of Atlantic City, recently arrived at the local Nike Base as the Group Medical Officer.

Dr. Isadore Lipkin, of Penns Grove again accepted chairmanship of the Diabetes Detection Program in Salem County. He advised that literature and test kits would soon be distributed.

The recent meeting of the Public Relations Council held in Trenton was discussed by Dr. Harry F. Suter, who stressed the interest generated by a discussion of the "Future Physicians Club." Dr. Suter suggested that the society appraise present needs and decide if local action might be advisable in an effort to secure more medical students.

Dr. Donald McLean of Salem reported on the meeting sponsored by the American Mutual Insurance Company about liability insurance. He outlined the rates and procedures involved.

The nominating committee (Drs. Harry W. Fullerton, C. B. Norton and Isadore Lipkin) was unanimously reelected for the coming year.

Dr. Spangler then introduced Dr. Ware, who spoke on Medical Care for the Aged. He pointed out that the signing of the Mills Bill into law will not stop the pressure for additional help for the aged by those supporting a program under Social Security. There will be continued efforts on the part of interested legislators to provide additional benefits. This subject is a controversial one. Dr. Ware noted that New Jersey's share of the fund requirements will be on a matching basis—50 per cent Federal and 50 per cent State. At this time, there is a lack of State funds for this in New Jersey.

After a brief question and answer period the members adjourned to dinner at 6:00 p.m.

FRANK W. WINTERS, M.D.

Reporter

Obituaries • • •

DR. NATHAN JAMES FURST

One of the state's pioneer radiologists, Dr. Nathan James Furst, died on September 15. Born in New York in 1890, he was graduated in 1912 from the medical school of the University of Pennsylvania. After interning at Passaic General Hospital, he became a medical officer in the Army of the United States and served during World War I. On returning from military service in 1919, he became interested in radiology, and did graduate work in that specialty at the New York Postgraduate.

He was affiliated with the Newark Beth Israel Hospital, serving in numerous ranks in the radiology department until 1929 when he became Director of Radiology and Roentgenology there—a position which he held until his retirement in the summer of 1960.

Dr. Furst was a Board diplomate in radiology and a past-president of our State Radiology Society. In 1942 he received the Award of Merit from The Medical Society of New Jersey.

DR. D. WEBB GRANBERRY

One of New Jersey's senior general practitioners died on September 22. Dr. D. Webb Granberry was born in Mississippi in 1877 and was graduated from the College of Physicians and Surgeons, Columbia University, in 1907. He was a governor of the Founders and Patriots of New Jersey and was for a quarter of a century president of the Glee Club of the Oranges. Dr. Granberry was affiliated with the Orange Memorial, the Mountainside and the Montclair Community Hospitals. He was a family doctor in Orange for over half a century.

DR. E. ZEH HAWKES†

Our state lost one of its most distinguished physicians on October 6 with the death that day of Dr. E. Zeh Hawkes. Dr. Hawkes had been president of the Essex County Medical Society, of the North Jersey Academy of Medicine, of the state Society of Surgeons and of The Medical Society of New Jersey. He was probably the first medical practitioner in New Jersey to have been trained in pathology. He was consultant at, or an attending surgeon at, most of the hospitals in and around Essex County.

Born in Schenectady in 1865, he was graduated in 1890 from Columbia University's College of Physicians and Surgeons. For the next several years, he served in the clinics and wards of the City and St. Michael's Hospitals in Newark. (In 1890 there were only 4 hospitals in Newark: St. Michael's, St. Barnabas, City and Eye and Ear.) He pioneered in many phases of medical practice—blood transfusions, bone grafts, biopsy studies, and spinal anesthesia—to name just a few. He rapidly became one of the leading practitioners in the state, and was selected as a member of the founding group of the American Surgeon's Club, which was the forerunner of the American College of Surgeons. His professional career (1890 to 1960) spanned the 70 most fruitful years of American Medicine.

DR. JACOB JOHN MANN

Dr. Jacob J. Mann, a Perth Amboy ophthalmologist and otolaryngologist, died on September 13 at the age of 67. A native of New York City, he was graduated in 1914 from the medical school of New York University and entered the Army of the United States the following year. At the conclusion of his military service, Dr. Mann entered private practice in Perth Amboy, and devoted himself to ophthalmology and otolaryngology. He became a diplomate in both specialties, and served the Perth Amboy General Hospital as director of Head and Neck Surgical Service. He was a surgical consultant to many hospitals in Middlesex County, and was active in the affairs of the Middlesex County Medical Society. He also had a tour of duty as an attending surgeon at the Newark Eye and Ear Infirmary, and as president of the staff of the Perth Amboy General Hospital.

DR. JAMES J. RITA

Dr. James J. Rita, a Trenton surgeon, died on September 25 at his home. Born in New York City in 1910, he was graduated in 1935 from Hahnemann. After his internship, he took a surgical residency at St. Francis Hospital in Trenton and then entered private practice of that specialty. He also had a tour of duty as Deputy County Physician. Dr. Rita was active in the affairs of the Mercer County Medical Society and was Associate Surgeon at the Helene Fuld Hospital.

---

†For an editorial on Dr. Hawkes, see page 613, this issue.

DR. D. WARD SCANLAN

On September 18, death closed the half-century medical career of Dr. D. Ward Scanlan, former medical director of the Atlantic City Hospital. Born in New York in 1887, he received his M.D. in 1911 from the University of Pennsylvania. He then crossed the Delaware and entered practice in Atlantic City, being affiliated with the hospital there in 1913. He held numerous offices at the hospital, serving twice as president of the staff and eventually as medical director. An internist, Dr. Scanlan was a diplomate of the American Board of Internal Medicine. He headed Atlantic City's Civil Defense station during World War II. He also was senior reserve officer in the U. S. Public Health Service, and a Fellow of the American College of Physicians.

DR. CHARLES D. SINKINSON, JR.

Dr. Charles D. Sinkinson, Jr., formerly chief of ear, nose and throat at the Atlantic City Hospital, died at that hospital on September 2. Born in Camden in 1893, Dr. Sinkinson received his medical degree from the University of Georgetown Medical School in 1916. He then entered the United States Navy, serving as a medical officer, and at the end of World War I opened an office for general practice in Atlantic City. He became increasingly interested in the nose and throat, and also served as a medical inspector of the Atlantic City public schools.

DR. GEORGE J. YOUNG

On October 2, 1960, death came to George J. Young. Officers and The Medical Society of New Jersey remember him as a long-term Treasurer. Born in Brooklyn in 1898, he received his M.D. degree at Cornell in 1926. He soon moved to Morristown where he became interested in pathology. He won staff affiliations at the Memorial and All Souls Hospitals in that city and at the general hospitals in Newton and Dover. He had several terms as chairman of the Morristown Board of Health and as secretary of the Morris County Medical Society. He was an ardent model railroad fan and after seven years of working on it, he opened a model railway that wound through three rooms in his Morristown home. From 1928 until 1952 he served the people of Morris County as an internist and clinical pathologist. And for many of those years he served all of us as Treasurer of our State Medical Society with an *ex officio* seat on the Board of Trustees. After a coronary attack in 1944 he carried on his practice without a let-up; but following a 1952 episode he retired to Chamberlain, Maine, where he died.

Book Reviews • • •

Fundamentals of Clinical Hematology. By Byrd S. Leavell, M.D. and Oscar A. Thorup, Jr., M.D. Philadelphia 1960. Saunders. Pp. 503, illustrated. ($10.00)

The authors have accomplished their purpose in introducing the readers to the fundamentals of clinical hematology. Chapter 3, on the mechanisms and diagnosis of anemia should be read by everyone who claims to practice any branch of medicine. The chapter on blood coagulation (theory and clinical applications) is a remarkable discussion of this field in hematology. It is an exceptionally lucid presentation of pertinent facts; and it enables the reader to become conversant with the terminology, which in the past has been somewhat confusing.

An excellent bibliography at the end of each chapter constitutes a ready reference for the student of hematology. The chapter on laboratory procedures is a useful compilation of methodology. The index is workable.

I am not convinced of the absolute accuracy of the statement made by the authors to the effect that punctuate basophilia or "stippling" is increased after exposure to lead and other metals. The statement that abnormal liver function tests may persist for long periods "up to 22 months in one report," following attacks of infectious mononucleosis, is highly significant.

The authors are to be congratulated for devoting not more than two lines to the so-called leukemoid reaction. The reviewer is convinced that the availability of bone marrow studies and other hematologic diagnostic procedures is such that this term should become obsolescent in hematologic terminology. Doctors Leavell and Thorup should have stressed more the importance of bone marrow studies prior to splenectomy in the treatment of thrombocytopenic purpura. I do not agree that there are any characteristic abnormalities in the peripheral blood of patients with Hodgkin's disease; yet this text is so worded that the casual reader might infer that the abnormalities in the

peripheral blood are principal manifestations of Hodgkin's disease in all cases.

In general, the print is on glossy paper, which makes the text easy to read. It is an informative, commendable and timely publication.

THOMAS K. RATHMELL, M.D.

Help-Bringers: Versatile Physicians of New Jersey. By Fred B. Rogers, M.D. New York 1960. Vantage Press. Pp. 125. ($2.95)

New Jersey doctors have a wonderful professional and spiritual legacy. Sometimes when the going seems tough, we can be cheered and inspired by realizing how much easier we have it than our medical ancestors in the 18th and 19th centuries. And we also have reason to wonder why so few of us today seem to measure up to the giants in our professional past.

In this illustrated and readable volume, Dr. Rogers gives us a dozen skillfully drawn verbal vignettes of forceful men who left their marks on the medical history, cultural development or civic enterprises of our State. All twelve were physicians—even as you and I. To read these sketches makes us at once humble and proud. Proud of the heritage these men bestowed on us; humble at our own smallness and narrowness. Perhaps our practice does not give us time for other activities. Perhaps medicine has become too "deep" and we have purchased depth at the price of breadth.

This happy little volume merits a place on the practitioner's book-shelf; or at his night table where, by reading one biography each evening, the doctor can get some idea of the kind of men whose torches we now carry. Dr. Rogers is a worthy chronicler and portrays well the flavor as well as the facts of our heritage.

VICTOR HUBERMAN, M.D.

A Doctor Enjoys Sherlock Holmes. Edward Van Liere, M.D. New York, 1960. Vantage Press. Pp. 141. ($3.00)

Since Sherlock Holmes' biographer was a physician, it is not surprising that there are many medical references in the Holmes stories. Dr. Van Liere here offers a series of entertaining and pleasant essays on Dr. Watson as a GP, as a meteorologist, as a physiologist, as a surgeon, geneticist, psychiatrist, and so on. The references are culled from the Sacred Writings and assembled by subject—with smooth and amusing commentaries by Dr. Van Liere. To the student of Sherlockiana, this is a book to be treasured. Incidentally, the Holmes stories give us an interesting sidelight into medical practice in England in the latter 19th century. A book to be dipped in, to be tasted an essay at a time, and not to be gulped whole!

HENRY A. DAVIDSON, M.D.

Doctor in Bolivia. By H. Eric Mautner. Philadelphia and New York 1960. Chilton Company. Pp. 331. ($5.95)

This is presented as the autobiography of an Austrian refugee although its main character bears a different name from that of the author. To the reviewer (who also had the stimulating experience of working in Bolivia for several years) there is much about the book that is disappointing. Dr. Mautner gives too little to the reader of the grandeur of the scenery, of the fascination of La Paz, which is one of the most unusual cities in the world; or the immensity and variation of the medical and other social problems against which this poor nation is struggling desperately.

The author deprecates local *curanderos* as personified by one of the characters. This ignores the fact that in such poor and sparsely populated areas there is usually no one else to minister to the sick. Much of what *curanderos* do is based upon generations of astute and intimate observation of the effects of a wide range of natural substances, a surprising number of which have proved to be efficacious. Quinine, rauwolfia and mercury are only a few of many possible examples.

It is difficult to obtain a clear image of the chief character or, for that matter of most of the others. From the title one would expect some significant discussion of the problems and work of a physician in the difficult circumstances of the location. However, with so much of great drama and interest that could be presented, the reviewer finished with a feeling that throughout, the main character, a physician, has merely vacillated between bouts of self-flagellation for not having fought back physically at the Nazis on the one hand, and repetitive debates with his conscience as to whether to crawl under some local senorita's mosquito net. As a result, the setting of the book might just as well have been any place in the world.

JOHN J. HANLON, M.D.

A Traveler's Guide to Good Health. Colter Rule Garden City, N. Y., 1960. Doubleday. Pp. 266. ($3.95)

Possibly unique among books of its kind is this useful manual on health while travelling. Dr. Rule tells about inoculations, drinking water in foreign countries, and clothing for comfort. He discusses digestive upsets, skin care, sea sickness, and eyestrain. He gives a handy listing of first aid for emergencies and suggests an excellent, compact "medical kit" for the traveller. There is an unusual "medical gazetteer" which gives a review of health hazards and suggestions about hospitals and doctors, country by country, in every part of the globe. And worth the price of admission is a quadrilingual medical lexicon (French, German, Italian, Spanish) covering everything from *La doleur a commence soudainment* to *Wechseljahre* and *Deseo comprar totallas sanitarias.* If you give one of these to a good patient about to take a trip abroad, it will be $3.95 well invested.

ULYSSES M. FRANK, M.D.

First Aid: Diagnosis and Management. By Warren H. Cole, M.D. and Charles B. Puestow, M.D. New York, 1960. Appleton-Century-Crofts. Pp. 432 with 217 illustrations. Ed. 5. ($6.25)

Since 1942 this has been recognized as one of the more sophisticated manuals of first aid. The list of contributing authors is a galaxy of well known physicians. The current edition includes new material on civilian defense, hand injuries and mass casualties. The chapter on radiation casualties has been updated. This book may be used by any physician as a training manual in teaching first aid to rescue squads, police officers, civilian defense cadets and fire departments. It is written with simplicity and clarity but never talks down to its readers. There are chapters on all types of emergencies, and the text includes material on the administrative aspects of casualty control. In all this is a solid manual for the doctor or first-aid man who wants to get above the A-B-C level.

ABRAHAM LEFF, M.D.

Cholinesterases: A Histochemical Contribution to Some Functional Problems. M. A. Gerebtzoff, M.D. New York, 1960. Pergamon Press. Pp. 195. ($8.50)

Most of us associate acetyl choline and cholinesterase with neuromuscular function. Dr. Gerebtzoff, however, has applied advanced histochemical technics to an intensive investigation of these substances in all the organs of the body. He has also studied their presence in several other animal species.

This research volume is a compendium of his findings. He describes in detail the quantitative distribution of the cholinesterases in the blood and lymph, in the nervous system and in the extraneural organs.

Clearly written and well illustrated, the material here is of interest primarily to physiologists and biochemists. It has no clinical application and is of little value to the practicing physician.

ROWLAND D. GOODMAN, 2ND, M.D.

Radio-isotope Studies of Fatty Acids. By J. F. Mead and D. R. Howton. New York 1960. Pergamon Press. Pp. 141. ($7.50)

New, effective tools take man too rapidly across gaps existing in various scientific fields for everyone to follow them closely.

This monograph describes in clear style the outstanding findings of the authorities who are devoted to the study of lipids, using a new, marvelous tool, the radioactive isotopes.

What they have recently proved or disproved by their work in relation to absorption, intimate metabolism of fatty acids, their catabolic products, transport and intermediary stages are outlined. Synthesis is considered in animals and plants.

Particularly appealing are the conscientious questions the authors set forth to the studious, pointing to the many secrets nature is keeping from us.

ALFRED ZAVALETA, M.D.

Edema: Mechanisms and Management. A Hahnemann Symposium on Salt and Water Retention. Edited by John H. Moyer, M.D. and Morton Fuchs, M.D., Philadelphia 1960. Saunders. Pp. 883, illus. ($15.00)

This volume on edema is an excellent presentation of the many facets and the many problems of "dropsy" which we have been treating for so many years in a state of blissful ignorance. The 123 contributors, including the editors, have truly presented the elements of chemistry, electrolyte balance, cardiac function, renal function, endocrine problems and so forth, which play a role, singly or in combination in producing edema. Further, all the drug therapy now in use is well documented and its mechanisms of action discussed by true workers in the field rather than by names who know about it. This gives a truly fine picture for the reader, making him better able to understand and evaluate the therapy. Another excellent practice is to give the trade name, where possible, along with the chemical name so that the average reader need not run to other reference books to find out what he is reading about. The index is good though some further cross-indexing would not have been amiss. The lack of an author's index makes it difficult to find a given individual's ideas when wanted. The panel discussions at the end of each of the sections do much to enhance the value of the book, since many interesting points never brought out in formal lectures or texts are discussed with great benefit to all. These are not well indexed, however, and so must be read carefully in their entirety for their pearls of wisdom.

This happy union of the chemist, physiologist, pharmacologist, clinical pharmacologist and clinician has truly produced a remarkable offspring worthy of being in every library as a reference text. By its use, the practitioner will avoid confusion and consternation when confronted with the overwhelming array of new diuretics and their supposed advantages which are often non-existent. Thus, the physician's patients will be benefited and he will be free of anxiety.

ARTHUR BERNSTEIN, M.D.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

NOVEMBER, 1960 • VOL. XXXIII, NO. 9

THE DANISH TUBERCULOSIS INDEX

An intensive study of the epidemiology of tuberculosis was undertaken in Denmark by the National Health Service of Denmark and the World Health Organization. A follow-up four years after a mass campaign of tuberculin testing, x-ray, and BCG vaccination showed that all persons with suspicious x-ray lesions and young people with large tuberculin reactions should be followed systematically; others could be ignored.

Tuberculosis eradication programs of the future must depend heavily on the establishment of risk rates in various definable population groups. It is only through a concentration of all resources for screening and supervision of those people most likely to develop tuberculosis that waste motion can be avoided and rapid progress made.

Giant steps in this direction have already been taken in Denmark by means of a mass screening campaign, followed by four years of careful observation. The report of this experience which appeared under the title, "Epidemiological Basis of Tuberculosis Eradication in Denmark," in the *Bulletin* of the World Health Organization, Vol. 21, No. 1, 1959, is of immediate practical importance to everyone involved in tuberculosis control. The authors were E. Groth-Peterson, Jorgen Knudsen, and Erik Wilbek. The whole study was carried out under an administrative organization called the Danish Tuberculosis Index. It was done as a cooperative undertaking of the National Health Service of Denmark and the WHO Tuberculosis Research Office.

COUNTRY-WIDE STUDY BEGUN

During the period from February, 1950 to December, 1952, tuberculin testing, x-raying, and BCG vaccinating teams covered the entire country with the exception of Copenhagen, the island of Bornholm and a few small communities where campaigns had been carried out previously. The only population group not included was school children aged 7 to 14 years who were being tuberculin tested and vaccinated in the schools. Over one million persons were examined. A sputum specimen or a gastric lavage was obtained whenever there were suspicious findings on the x-ray.

Among the 795,000 adults examined in the mass campaign, 503 previously unknown cases of active pulmonary tuberculosis were found—a rate of one case per 1,500 examined. Expressed as age specific rates per 100,000 population, there was a range from 36 in men aged 15 to 24 to 94 in women aged 25 to 34. The report provides the greatest detail on the cases found during the initial campaign, but the findings in the four-year period of follow-up are striking, indeed, and furnish valuable documentation on risk rates not previously available for any population group in the world.

FOUR-YEAR FOLLOW-UP

Among the 744,261 individuals judged healthy, so far as tuberculosis is concerned, at the start of the follow-up period, 878 new cases of tuberculosis developed, 742 of which were pulmonary. This is an average annual incidence of 25 per 100,000. Although the rates were somewhat

F. M. Feldmann, M.D., *National Tuberculosis Bulletin, No. 8, Vol. 46, September, 1960.*

higher for women and for the age group 15 to 34, the differences are too small to be of much use in defining risk groups. It is only when tuberculin test and x-ray results are considered together that big differences in risk rates become evident.

In a group of 320,000 unvaccinated tuberculin reactors, the average annual case rates per 100,000 in the age group 15 to 24, according to size of tuberculin reaction, were as follows: 6 to 11 millimeters, 24.5; 12 to 17 mm., 56.4; 18 to 23 mm., 87.8; and 24+ mm., 72.6. In older persons, the differences by size of reaction were less striking.

X-ray findings at the start of the follow-up period were classified as normal (90 per cent), healed lesions (7 per cent), and suspicious (3 per cent). The corresponding new average annual case rates were 27, 51 and 370, respectively, for all ages. However, the rate was 1,022 for those in the age group 15 to 24 who had suspicious shadows. The highest case rate—roughly 2,000 per 100,000 persons per year—was in a subgroup of 1,200 persons whose roentgenographic findings were interpreted as definite lesions, probably of tuberculosis origin.

Although the case rates in the vaccinated groups were low, 23 per cent of the new cases arose among them. Since there was no unvaccinated control group selected at random, the effect of vaccination could not be measured.

CONCLUSIONS

The report concludes: "Certainly the enormous numbers of routine repetitive x-ray examinations of adults can be drastically reduced and the case-finding nevertheless intensified. Persons in the older age-groups with normal findings on a single photofluorogram, even though they have positive tuberculin reactions, need not be called back for examination year after year. They can be left in peace. But persons of any age with suspicious x-ray lesions and young people with large tuberculin reactions should be followed systematically. These high-risk groups comprise such a small percentage of the total population that continuous and close supervision is both practicable and profitable."

NEW JERSEY TRUDEAU SOCIETY
is the medical section of
NEW JERSEY TUBERCULOSIS AND HEALTH ASSOCIATION
15 EAST KINNEY STREET, NEWARK 2, NEW JERSEY

IN EMOTIONALLY PROJECTED SMOOTH-MUSCLE SPASM...

Prompt, Profound Protection...at both ends of the vagus

PRO-BANTHĪNE® *with* DARTAL®

Professional reliance on the therapeutic proficiency of Pro-Banthīne in functional gastrointestinal disorders has made it the most widely prescribed anticholinergic.

The consistent relief of emotional tensions afforded by Dartal makes this well-tolerated tranquilizer a rational choice to support the antispasmodic action of Pro-Banthīne in emotionally influenced smooth-muscle spasm.

These two reliable agents combined as Pro-Banthīne with Dartal consistently control both disturbed mood and disordered motility when emotional disturbances project themselves through the vagus to provoke such gastrointestinal dysfunctions as gastritis, pylorospasm, peptic ulcer, spastic colon or biliary dyskinesia.

USUAL ADULT DOSAGE:
One tablet three times a day.

SUPPLIED as aqua-colored, compression-coated tablets containing 15 mg. of Pro-Banthīne (brand of propantheline bromide) and 5 mg. of Dartal (brand of thiopropazate dihydrochloride).

G. D. SEARLE & CO.
Chicago 80, Illinois
Research in the Service of Medicine

basic in the care of the aging

Metalex®

when body tone, mental and sensory faculties begin to fade—*she's irritable, confused, forgetful, apathetic*

when vision begins to dim—*in loss of visual acuity, in loss of peripheral vision*

when voices begin to fade—*in loss of auditory acuity, in tinnitus*

Metalex® *cerebral stimulant/vasodilator*

The stimulant—pentylenetetrazol—facilitates cerebral and reflex nerve activity.

The vasodilator—nicotinic acid—augments blood and oxygen supply to vital areas—

Thus, METALEX increases body tone and aids mental and sensory faculties.

Composition: Each teaspoonful (5 ml.) of the Elixir and each Tablet contains: Pentylenetetrazol 100 mg., Nicotinic Acid 50 mg.

Dosage: One or two teaspoonfuls of the Elixir or one or two Tablets four times a day—one-half hour before meals and before bedtime.

Available: Elixir: Pint and Gallon bottles. Tablets: Bottles of 100 and 1000.

References: 1. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics, 2nd Ed., New York, Macmillan Company, 1955. 2. O'Reilly, P. O., Demay, M. and Kotlowski, K.: Cholesteremia and Nicotinic Acid. A.M.A. Arch. Int. Med. 100:797-801 (Nov.) 1957.

STORCK Pharmaceuticals, Inc.,
2326 Hampton Blvd., St. Louis 10, Mo.

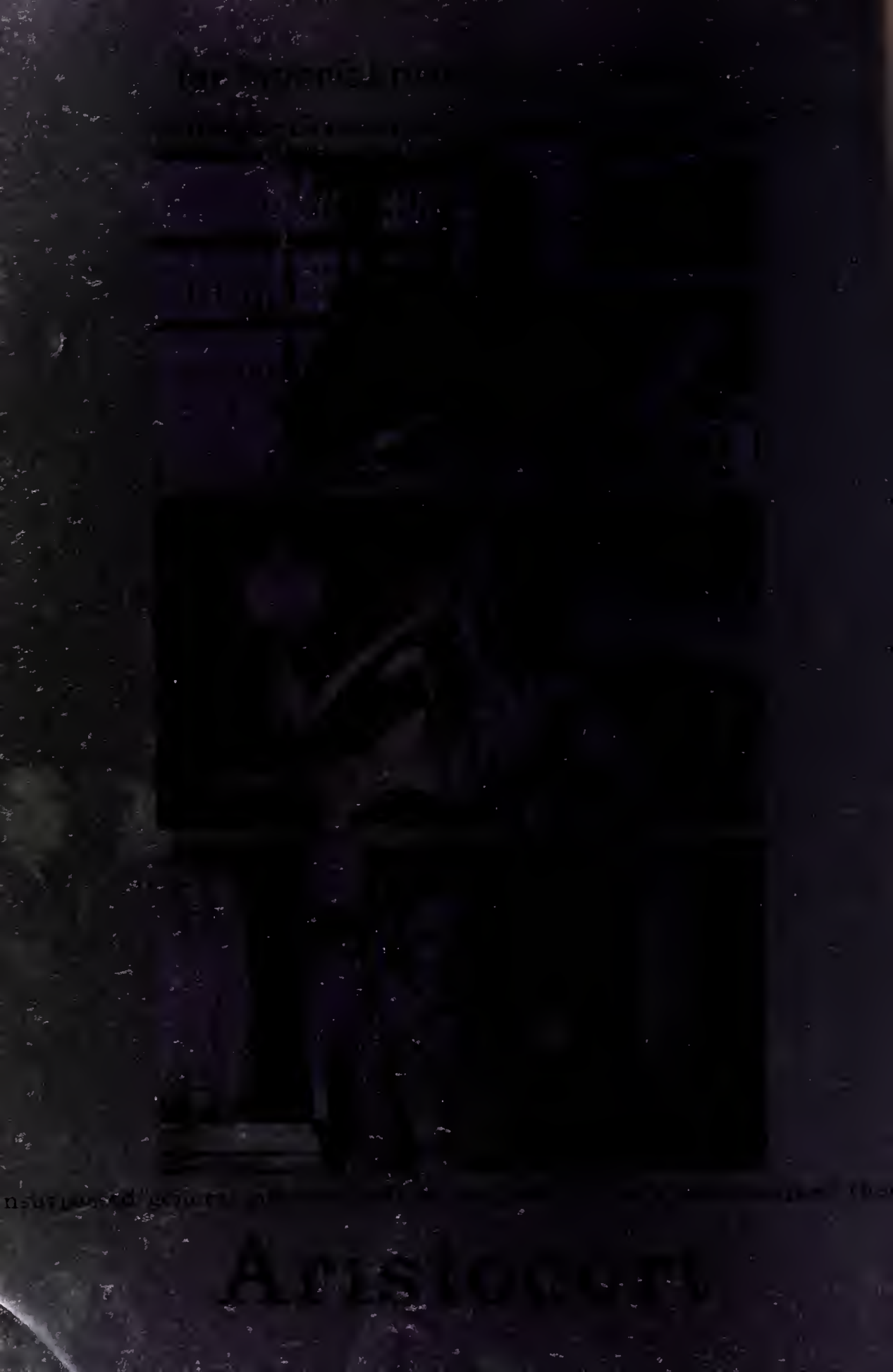
UNSURPASSED "GENERAL-PURPOSE" CORTICOSTEROID . . .

Aristocort®

Triamcinolone LEDERLE

OUTSTANDING FOR "SPECIAL-PURPOSE" THERAPY

Lederle



Aristocort

Triamcinolone has long since proved its unsurpassed efficacy and relative safety in the therapy of *rheumatoid arthritis, inflammatory and allergic dermatoses, bronchial asthma,* and all other conditions in which corticosteroids are indicated. But ARISTOCORT has also opened up new areas of therapy for selected patients who otherwise could not be given corticosteroids. Medicine is now in an era of "special-purpose" steroids.[1]

One outstanding advantage of triamcinolone is that it rarely produces edema and sodium retention.[1,2]

The clinical importance of this property cannot be overemphasized in treating certain types of patients. McGavack and associates[3] have reported the beneficial results with ARISTOCORT in patients with existing or impending cardiac failure, and those with obesity associated with lymphedema. Triamcinolone, in contrast to most other steroids, is not contraindicated in the presence of edema or impending cardiac decompensation.[3]

Hollander[1] points out the superiority of triamcinolone in not causing mental stimulation, increased appetite and weight gain, compared to other steroids which produce these effects in varying degrees. And McGavack,[2] in a comparative tabulation of steroid side effects, indicates that triamcinolone does not produce the increased appetite, insomnia, and psychic disturbances associated with other newer steroids.

ARISTOCORT can thus be advantageous for patients requiring corticosteroids whose appetites should not be stimulated, and for those who are already overweight or should not gain weight. Likewise, ARISTOCORT is suitable for the many patients with emotional and nervous disorders who should not be subjected to psychic stimulation. Furthermore, ARISTOCORT Triamcinolone, in effective doses, showed a low incidence of side reactions and is a steroid of choice for treating the older patient in whom salt and water retention may cause serious damage.[2]

References: 1. Hollander, J. L.: *J.A.M.A.* 172:306 (Jan. 23) 1960. 2. McGavack, T. H.: *Nebraska M. J.* 44:377 (Aug.) 1959. 3. McGavack, T. H.; Kao, K. Y. T.; Leake, D. A.; Bauer, H. G., and Berger, H. E.: *Am. J. M. Sc.* 236:720 (Dec.) 1958.

Precautions: Collateral hormonal effects generally associated with corticosteroids may be induced. These include Cushingoid manifestations and muscle weakness. However, sodium and potassium retention, edema, weight gain, psychic aberration and hypertension are exceedingly rare. Dosage should be individualized and kept at the lowest level needed to control symptoms. It should not exceed 36 mg. daily without potassium supplementation. Drug should not be withdrawn abruptly. Contraindicated in herpes simplex and chicken pox.

Supplied: Scored tablets—1 mg. (yellow); 2 mg. (pink); 4 mg. (white); 16 mg. (white).

Lederle

LEDERLE LABORATORIES, A Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

More than keeping abreast . . . keeping ahead!

Plan to attend the

AMA 14th Clinical Meeting

Washington, D.C.

Registration and Exhibits
National Guard Armory
November 28, 29, 30, December 1

Use any means but by all means attend this session—an informative cross-section of medicine for all physicians.

☆ **OVER 100 SCIENTIFIC PAPERS**

☆ **OVER 100 SCIENTIFIC EXHIBITS**

☆ **OUTSTANDING SYMPOSIA & PANELS**

- Coronary Artery Disease
- Clinical Nutrition
- Panel on Nodules
- Panel on Antibiotics and Steroids

See October 1 and October 22 JAMA for hotel and meeting registration forms . . . Complete scientific program of Clinical Meeting appears in October 22 JAMA

AMERICAN MEDICAL ASSOCIATION

535 North Dearborn Street, Chicago 10, Illinois

The physician listens to a tense, nervous patient discuss her emotional problems. To help her, he prescribes Meprospan® (400 mg.), the only continuous-release form of meprobamate.

The patient takes one Meprospan-400 capsule at breakfast. She has been suffering from recurring states of anxiety which have no organic etiology.

She stays calm while on Meprospan, even under the pressure of busy, crowded supermarket shopping. And she is not likely to experience any autonomic side reactions, sleepiness or other discomfort.

She takes another capsule of Meprospan-400 with her evening meal. She has enjoyed sustained tranquilization all day—and has had no between-dose letdowns. Now she can enjoy sustained tranquilization all through the night.

Relaxed, alert, attentive . . . she is able to listen carefully to P.T.A. proposals. For Meprospan does not affect either her mental or her physical efficiency.

Peacefully asleep . . . she rests, undisturbed by nervousness or tension. (Samples and literature on Meprospan available from Wallace Laboratories, Cranbury, N. J.)

Medical education needs your dollars
to stay strong and free . . .

Give to the school of your choice through AMEF

To train the doctors of tomorrow, the nation's medical schools must have your help today. It is a physician's unique privilege and responsibility to replenish his own ranks with men educated to the highest possible standards. *Invest in the future health of the nation and your profession. Send your check today!*

American Medical Education Foundation

AMEF

535 North Dearborn Street
Chicago 10, Illinois

IN COLDS AND SINUSITIS— THE RIGHT AMOUNT OF "INNER SPACE" RIGHT AWAY

Neo-Synephrine hydrochloride relieves the boggy feeling of colds immediately and safely, without causing systemic toxicity or chemical harm to nasal membranes. Turbinates shrink, sinus ostia open, ventilation and drainage resume, and mouth-breathing is no longer necessary.

Gentle Neo-Synephrine shrinks nasal membranes for from two to three hours without stinging or harming delicate respiratory tissues. Post-therapeutic turgescence is minimal. Neo-Synephrine does not lose its effectiveness with repeated applications nor does it cause central nervous stimulation, jitters, insomnia or tachycardia.

Neo-Synephrine solutions and sprays produce shrinkage of tissue without interfering with ciliary activity or the protective mucous blanket.

For wide latitude of effective and safe treatment, Neo-Synephrine hydrochloride is available in nasal sprays for adults and children; in solutions from ⅛% to 1%; and in aromatic solution and water soluble jelly.

Winthrop LABORATORIES
New York 18, N. Y.

NEO-SYNEPHRINE®
(Brand of phenylephrine hydrochloride)
hydrochloride

NASAL SOLUTIONS AND SPRAYS

ANNUAL CLINICAL CONFERENCE

Chicago Medical Society

FEBRUARY 28, MARCH 1, 2 and 3, 1961

PALMER HOUSE, CHICAGO

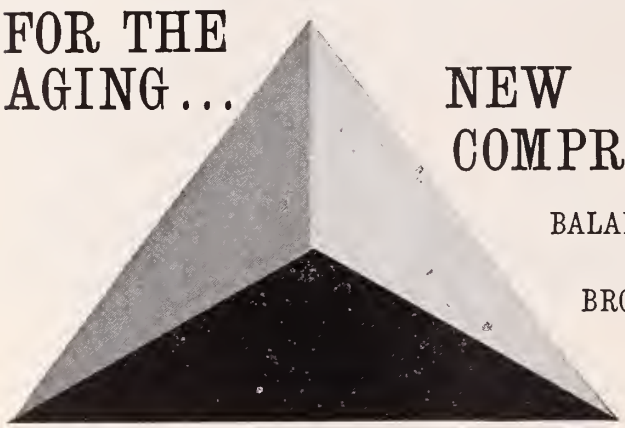
Daily Half-Hour Lectures by Outstanding Teachers and Speakers on subjects of interest to both general practitioner and specialist.

Panels on Timely Topics **Teaching Demonstrations**
Medical Color Telecasts **Instructional Courses**

Scientific Exhibits worthy of real study and helpful and time-saving Technical Exhibits.

The Chicago Medical Society Annual Clinical Conference should be a **MUST** on the calendar of every physician. Plan now to attend and make your reservations at the Palmer House.

FOR THE AGING...



NEW COMPREHENSIVE SUPPORT

BALANCED HORMONE SUPPLEMENTATION
▲
BROAD NUTRITIONAL REINFORCEMENT
▲
MOOD ELEVATION

NEW 1 small capsule every morning

GEVRESTIN®

Geriatric Vitamins-Minerals-Hormones-d-Amphetamine Lederle

Each capsule contains: Ethinyl Estradiol 0.01 mg. • Methyl Testosterone 2.5 mg. • d-Amphetamine Sulfate 2.5 mg. • Vitamin A (Acetate) 5,000 U.S.P. Units • Vitamin D 500 U.S.P. Units • Vitamin B_{12} with AUTRINIC® Intrinsic Factor Concentrate 1/15 U.S.P. Unit (Oral) • Thiamine Mononitrate (B_1) 5 mg. • Riboflavin (B_2) 5 mg. • Niacinamide 15 mg. • Pyridoxine HCl (B_6) 0.5 mg. • Calcium Pantothenate 5 mg. • Choline Bitartrate 25 mg. • Inositol 25 mg. • Ascorbic Acid (C) as Calcium Ascorbate 50 mg. • l-Lysine Monohydrochloride 25 mg. • Vitamin E (Tocopherol Acid Succinate) 10 Int. Units • Rutin 12.5 mg. • Ferrous Fumarate (Elemental iron, 10 mg.) 30.4 mg. • Iodine (as KI) 0.1 mg. • Calcium (as $CaHPO_4$) 35 mg. • Phosphorus (as $CaHPO_4$) 27 mg. • Fluorine (as CaF_2) 0.1 mg. • Copper (as CuO) 1 mg. • Potassium (as K_2SO_4) 5 mg. • Manganese (as MnO_2) 1 mg. • Zinc (as ZnO) 0.5 mg. • Magnesium (MgO) 1 mg. • Boron (as $Na_2B_4O_7.10H_2O$) 0.1 mg. Bottles of 100, 1000.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

for acute
upper respiratory infections

Tetrex® capsules

The Original Tetracycline Phosphate Complex

U.S. PAT. NO. 2,791,609

effective control of pathogens...with an unsurpassed record of safety and tolerance

BRISTOL LABORATORIES, SYRACUSE, NEW YORK
Div. of Bristol-Myers Co.

BRISTOL ™

SUPPLY: TETREX Capsules — tetracycline phosphate complex — each equivalent to 250 mg. tetracycline HCl activity. Bottles of 16 and 100.

TETREX Syrup — tetracycline (ammonium polyphosphate buffered) syrup — equivalent to 125 mg. tetracycline HCl activity per 5 ml. teaspoonful. Bottles of 2 fl. oz. and 1 pint.

PRESCRIPTION PHARMACISTS

TO THE MEMBERS OF

The Medical Society of New Jersey

PLACE	NAME AND ADDRESS	TELEPHONE
BELLEVILLE	Joralemon Pharmacy, 531 Joralemon St.	PLym'th 9-4535-9858
BERGENFIELD	Horn's Pharmacy, 475 So. Washington Ave.	DUmont 4-1119
BLOOMFIELD	Burgess Chemist, 56 Broad St.	PIlgrim 3-1005
BOONTON	Preston Drugs, Del's Village Shopping Center	DEerfield 4-3466
BOUND BROOK	Lloyd's Drug Store, 305 East Main St.	ELliot 6-0150
BUTLER	Pink's Pharmacy, 178 Main St.	BUtler 9-0090, 9-1063
CLOSTER	Mid Town Pharmacy, 237 Closter Dock Road	CLoster 5-0070
DOVER	Leslie's Drugs, Inc., 9 East Blackwell St.	FOxcroft 6-1405
DUMONT	Lenrow's Pharmacy Inc., 10 W. Madison Ave.	DUmont 4-0842-1500
EDISON TOWNSHIP	Walter's Pharmacy, 1034 Amboy Ave.	LIberty 8-2614
EMERSON	Emerson Pharmacy, 201 Kinderkamack Road	COlfax 2-4999
FLEMINGTON	Green's Pharmacy, 52 Main St.	FLemington 108
FORDS	Fords Pharmacy, Inc., 550 New Brunswick Ave.	HIllcrest 2-4568
GLOUCESTER	King's Pharmacy, Broadway and Market Sts.	GLouc't'r 6-0781-8970
HAWTHORNE	Melcon's Pharmacy, 207 Diamond Bridge Ave.	HAwthorne 7-1546
HIGHLANDS	Highlands Pharmacy, 148 Bay Ave.	HIghlands 3-1058
JERSEY CITY	The Cole Pharmacy, Inc., 710 Grand St.	Delaware 3-9294
JERSEY CITY	J. B. Feinberg Pharmacy, 659 Newark Ave.	OLdfield 3-6376
JERSEY CITY	Honiberg Drug & Surgical Supply Co., 618 Newark Ave.	SWarthmore 8-6700
JERSEY CITY	Lauria's Pharmacy, 768 West Side Ave.	HEnderson 3-1519
JERSEY CITY	Waters Pharmacy, 492 Jackson Ave.	DElaware 3-3043
KEYPORT	Sav-On-Drugs, J. Meisler, opp. Post Office	COlfax 4-0904
LITTLE FALLS	Swisher Pharmacy, Inc., 94 Main St.	CLifford 6-0835
MILLTOWN	Milltown Pharmacy, 21 No. Main St.	MIlltown 8-0081
MILLVILLE	Richard H. Knowles Pharmacy, 600 No. High St.	TAylor 5-0721
MOORESTOWN	Stiles' Pharmacy, 75 East Main St.	BElmont 5-0088
MORRISTOWN	Carrell's Pharmacy (N. E. Corrao, Pharm.) 31 South St.	JEfferson 9-0143
MORRISVILLE, PA.	Pryor's Pharmacy, Bridge St. & Penna. Ave.	CYpress 5-7416
MOUNT HOLLY	Goldy's Pharmacy, Main & Washington Sts.	AMherst 7-3800
MOUNT HOLLY	Mount Holly Pharmacy, 64 Main St.	AMherst 7-0453
NEWARK	Giannotto's Pharmacy, 195 First Ave.	HUmboldt 2-8220
NEWARK	G. Maggio's Prescription Pharmacy, 136 Fleming Ave.	MItchell 2-8915
NEWARK	Marquier's Pharmacy, Sanford & So. Orange Aves.	ESsex 3-7721
NEWARK	Smith's Pharmacy, 315 So. Orange Ave.	MArket 3-1514

(Continued on following page)

PRESCRIPTION PHARMACISTS

TO THE MEMBERS OF

The Medical Society of New Jersey

(Continued from preceding page)

NEW BRUNSWICK	Bode Drug Co., 120 French St.	KIlmer 5-2676
NEW BRUNSWICK	Hoagland's Drug Store, 365 George St.	KIlmer 5-0048
NEW BRUNSWICK	Rutgers Pharmacy, 429 Livingston Ave.	CHarter 9-6666
NEW BRUNSWICK	Tobin's Drug Store, 335 George St.	CHarter 9-0780
NEW BRUNSWICK	Zajac's Pharmacy, 225 George St.	KIlmer 5-0582
OCEAN CITY	Selvagn's Pharmacy, 862 Asbury Ave.	OCean City 3535
ORANGE	Highland Pharmacy, 536 Freeman St.	ORange 3-1040
ORANGE	Hollywood Pharmacy, 49 Central Ave.	ORange 5-1752
PASSAIC	Wollman Pharmacy, 143 Prospect St.	PRescott 9-0081
PATERSON	Vallario's Pharmacy, 357 Totowa Ave.	ARmory 4-2139
PAULSBORO	Nastase's Pharmacy, 762 Delaware St.	PAulsboro 8-1569
PERTH AMBOY	Jacobs' Drug Store, 434 Amboy Ave.	VAlley 6-3273
PITMAN	Lodge's Pharmacy, 39 So. Broadway	LUther 9-2392
PRINCETON	The Thorne Pharmacy, 168 Nassau St.	WAlnut 4-0077
RAHWAY	Kirstein's Pharmacy, 74 East Cherry St.	RAhway 7-0235
RIDGEFIELD PARK	Lloyd's Prescriptions, 209 Main St.	DIamond 2-8383
RIDGEWOOD	Davis Pharmacy, Inc., 2 Wilsey Square	OLiver 2-2444
ROCKAWAY	Leslie's Drugs, Inc., 36 West Main St.	OAkwood 7-5544
RUMSON	Rumson Pharmacy, W. E. Fogelson	RUmson 1-1234
SOUTH AMBOY	Madura Pharmacy, 115 N. Broadway	PArkway 1-1732
SOUTH ORANGE	Taft's Pharmacy, 2 South Orange Ave.	SOuth Orange 2-0063
TRENTON	Adams & Sickles, State & Prospect Sts.	OWen 5-6396
TRENTON	Delahanty's Pharmacy, State St. at Chambers	EXport 3-4261
TRENTON	Episcopo's Pharmacy, Chambers & Liberty Sts.	EXport 3-3017
TRENTON	Foy's Drug Store, 3024 So. Broad St.	EXport 3-2367
TRENTON	H. S. Hughes, Thatcher Pharmacy, 401 Hudson St.	EXport 2-5616
TRENTON	Kahr's Pharmacy, A. F. Capriotti, R. P., M.P.A.	OWen 5-6807
UNION	Perkins Union Center Pharmacy	MUrdock 6-0877
UNION CITY	Husni's Pharmacy, 2503 Bergenline Ave.	UNion 5-2577
UNION CITY	Jos. Parentini's Pharmacy, Inc., Charles H. Arnoldi	UNion 7-4806
WEST NEW YORK	The Owl Pharmacy, 6611 Bergenline Ave.	UNion 5-0384
WEST ORANGE	West Orange Pharmacy, 443 Main St.	ORange 4-9824
WRIGHTSTOWN	Bowen's Pharmacy, 152 Fort Dix Road	RAymond 3-2176

benzthiazide

NaClex®

a new molecule with an unsurpassed faculty for salt excretion

A. H. Robins announces NaClex, a potent, oral, nonmercurial diuretic. NaClex is a new molecule, designated benzthiazide. Its unique chemical structure produces a "pronounced increase in diuretic potency"[1] over many older diuretics. NaClex also has antihypertensive properties, and it enhances the activity of other antihypertensive drugs.

in diuresis

salt removal is still the fundamental objective

As salt goes, so goes edema

A fundamental principle of diuresis is that "increased urine volume and loss of body weight are proportional to and the osmotic consequences of loss of ions."[2] New NaClex helps reduce edema through the application of this basic principle.

Apparently functioning in the proximal renal tubules, NaClex strictly limits the reabsorption of sodium and chloride ions. To maintain the essential, subtle balance between salt and water, the body's homeostatic mechanism reponds to this loss of ions by allowing an increased excretion of excessive extracellular water. Thus the NaClex-induced removal of salt leads directly to the reduction of edema.

How potent is benzthiazide?

Compared tablet for tablet with oral diuretics now available, NaClex is unsurpassed in potency. Milligram for milligram, it has achieved optimum diuresis in pharmacologic studies at 1/20 the dose required for chlorothiazide.

What are the major diuretic indications for NaClex?

NaClex produces diuresis, weight loss, and symptomatic improvement in edema associated with conditions such as congestive heart failure, cirrhosis of the liver, chronic renal diseases (including nephrosis), premenstrual tension, toxemia of pregnancy, and obesity. Edema of local origin and that caused by steroids may also benefit.

To what extent is NaClex useful in hypertension?

NaClex has definite antihypertensive properties, and may be used alone in mild hypertension. In severer cases it may be used with other antihypertensive drugs, potentiating them and permitting their use at lower dosage. In hypertension with associated water retention, NaClex is of twofold value. It may be prescribed for congestive heart failure as an ancillary measure to digitalis.

Is potassium excretion a problem with NaClex?

In short-term therapy, excessive potassium excretion is unlikely. In the effective dose range, potassium loss varies from ⅙ to ½ that of sodium. Naturally, the ratio of these ions depends on the rate at which excess sodium stores are depleted, and whether salt intake is restricted.

Can NaClex and mercurials be given concurrently?

Yes. When so employed, NaClex may increase the efficacy of mercurials. But NaClex alone is often effective enough to eliminate the need for parenteral mercurial administration. Also, NaClex may be effective in cases when mercurials are not.

Supply: Available in yellow, scored 50 mg. tablets.

References: 1. Ford, R. V., Cur. Therap. Res., 2:51, 1960. 2. Pitts, R. F., Am. J. Med., 24:745, 1958.

For complete dosage schedules, precautions, or other information about new NaClex, please consult basic literature, package insert, or your local Robins representative, or write to A. H. Robins Co., Inc., Richmond, Va.

A. H. ROBINS COMPANY, INC.
RICHMOND 20, VIRGINIA

PHARMACEUTICALS 1878 RESEARCH

3-dimensional support for older patients

BOLSTERS... ▲ *tissue metabolism*
▲ *interest, vitality*
▲ *failing nutrition*

NEW 1 small capsule every morning

GEVRESTIN®

Geriatric Vitamins-Minerals-Hormones-d-Amphetamine Lederle

Each capsule contains: Ethinyl Estradiol 0.01 mg. • Methyl Testosterone 2.5 mg. • d-Amphetamine Sulfate 2.5 mg. • Vitamin A (Acetate) 5,000 U.S.P. Units • Vitamin D 500 U.S.P. Units • Vitamin B_{12} with AUTRINIC® Intrinsic Factor Concentrate 1/15 U.S.P. Unit (Oral) • Thiamine Mononitrate (B_1) 5 mg. • Riboflavin (B_2) 5 mg. • Niacinamide 15 mg. • Pyridoxine HCl (B_6) 0.5 mg. • Calcium Pantothenate 5 mg. • Choline Bitartrate 25 mg. • Inositol 25 mg. • Ascorbic Acid (C) as Calcium Ascorbate 50 mg. • l-Lysine Monohydrochloride 25 mg. • Vitamin E (Tocopherol Acid Succinate) 10 Int. Units • Rutin 12.5 mg. • Ferrous Fumarate (Elemental iron, 10 mg.) 30.4 mg. • Iodine (as KI) 0.1 mg. • Calcium (as $CaHPO_4$) 35 mg. • Phosphorus (as $CaHPO_4$) 27 mg. • Fluorine (as CaF_2) 0.1 mg. • Copper (as CuO) 1 mg. • Potassium (as K_2SO_4) 5 mg. • Manganese (as MnO_2) 1 mg. • Zinc (as ZnO) 0.5 mg. • Magnesium (MgO) 1 mg. • Boron (as $Na_2B_4O_7.10H_2O$) 0.1 mg. Bottles of 100, 1000.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Protection against loss of income from accident and sickness as well as hospital expense benefits for you and all your eligible dependents.

PHYSICIANS CASUALTY & HEALTH ASSOCIATIONS

OMAHA 31, NEBRASKA

ALL PREMIUMS COME FROM — PHYSICIANS SURGEONS DENTISTS — ALL BENEFITS GO TO

Since 1902
Handsome Professional Appointment Book sent to you FREE upon request.

THE ORANGE PUBLISHING CO.

PRINTERS

•

116-118 Lincoln Avenue
Orange, N. J.

THE CRANE PLAN is the fruit of 30 years experience and research in billing and collecting current and past due accounts for members of The Medical Society of New Jersey.

CRANE DISCOUNT CORP.
Executive Offices
221 WEST 41st STREET
NEW YORK 36, N. Y.

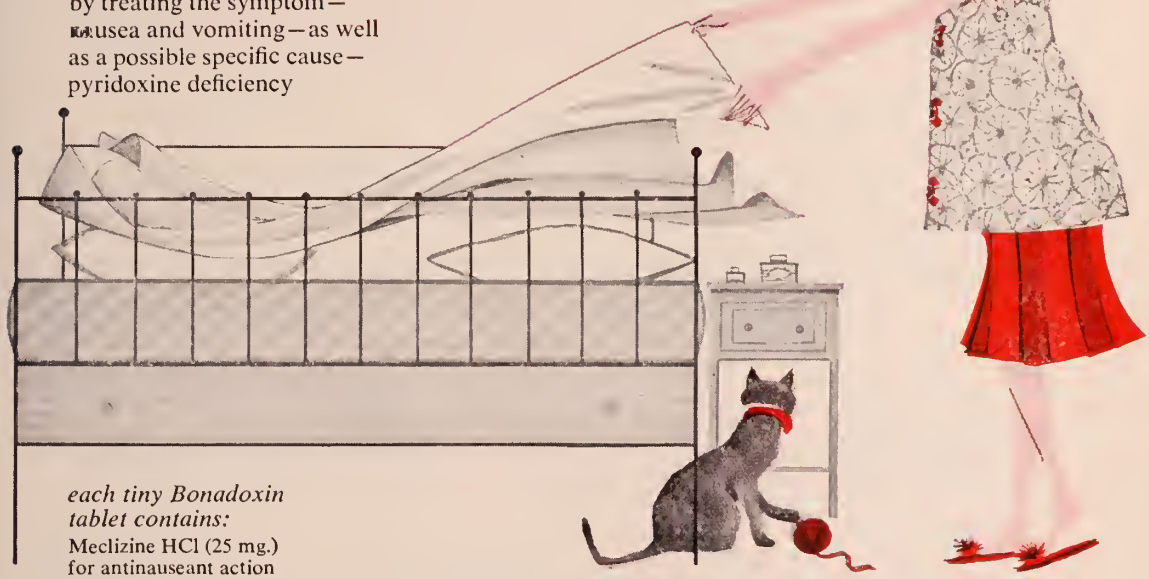
taken at bedtime

BONADOXIN®

STOPS MORNING SICKNESS IN 94%

OFTEN WITH JUST ONE TABLET DAILY

by treating the symptom—nausea and vomiting—as well as a possible specific cause—pyridoxine deficiency



each tiny Bonadoxin tablet contains:
Meclizine HCl (25 mg.) for antinauseant action
Pyridoxine HCl (50 mg.) for metabolic replacement.

usual dose: One tablet at bedtime; severe cases may require another tablet on arising.

supply: Bottles of 25 and 100 tablets. Bonadoxin also effectively relieves nausea and vomiting associated with: anesthesia, radiation sickness, Meniere's syndrome, labyrinthitis, and motion sickness. Also useful in postoperative nausea and vomiting.

Bibliography on request.

For infant colic, try Bonadoxin Drops. Each cc. contains: Meclizine 8.33 mg./ Pyridoxine 16.67 mg.

New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being™

and...when your OB patient needs the best in prenatal vitamin-mineral supplementation...
OBRON®

Not Just "Milk" But . . .

WALKER-GORDON CERTIFIED MILKS

There are many reasons why thousands of discriminating families have been raised from infancy on Walker-Gordon Certified Milks. Among the reasons:

- *Super-Sanitary Production Methods.* From cow to bottle, milk is never exposed to air or human touch.
- *Cleanest.* Lowest bacteria count. Laboratory on the farm.
- *Freshest.* Bottled immediately after milking, usually delivered the following day. Keeps for weeks under normal refrigeration.
- *Uniform.* No variance in flavor or nutritional value, 365 days a year.

Guaranteed Free of Penicillin

Certified Milks available through Leading Milk Dealers: Raw, Pasteurized, Homogenized-Vitamin D, Skimmed, Acidophilus, Fresh Lo-Sodium. Write for complete information.

WALKER-GORDON CERTIFIED MILK FARM

Plainsboro, N.J. ***SWinburne 9-1234***

NEW YORK: WAlker 5-7300 ★ **PHILA.: LOcust 7-2665**

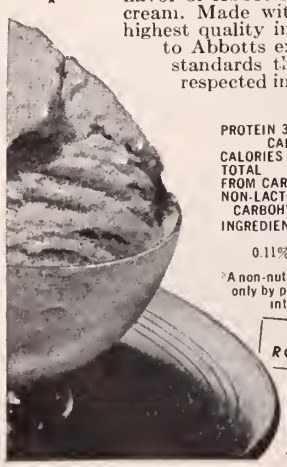
***NOW!* DIABETICS CAN ENJOY**
(UNDER MEDICAL ADVICE)

Abbotts

ARTIFICIALLY SWEETENED

ICE CREAM

Your patients whose sugar intake is restricted will relish the extra delicious flavor of Abbotts new, sugar-free ice cream. Made with infinite care and highest quality ingredients according to Abbotts exacting standards—standards that are most highly respected in the dairy industry.



COMPOSITION

PROTEIN 3.52%	MILK FAT 10.52%	
CARBOHYDRATES 21.35%		
CALORIES PER OUNCE	AVOIR.	FLUID
TOTAL	55.02	33.31
FROM CARBOHYDRATES	24.21	14.66
NON-LACTOSE CARBOHYDRATES	18.03	10.92

INGREDIENTS: CREAM, MILK, SORBITOL, STABILIZER AND 0.11% CYCLAMATE CALCIUM*

*A non-nutritive artificial sweetener for use only by persons who must restrict their intake of ordinary sweets.

IN HANDY ROUND PINTS

At Abbotts and Jane Logan Dealers
Abbotts Dairies, Inc.

Dugan's
"Bakers for the Home"

New - LITE DIET BREAD

(White Bread Baked Without Shortening)
Calories per Slice 42 Calories per Oz. 70

ALSO

SALT-FREE BREAD
GLUTEN AND PROTEIN BREADS
100% WHOLE WHEAT
100% Whole Wheat Crackers

New York New Jersey
Connecticut Pennsylvania

"AT YOUR DOOR OR TO YOUR STORE, IT'S DUGAN'S FOR BETTER BAKED GOODS"

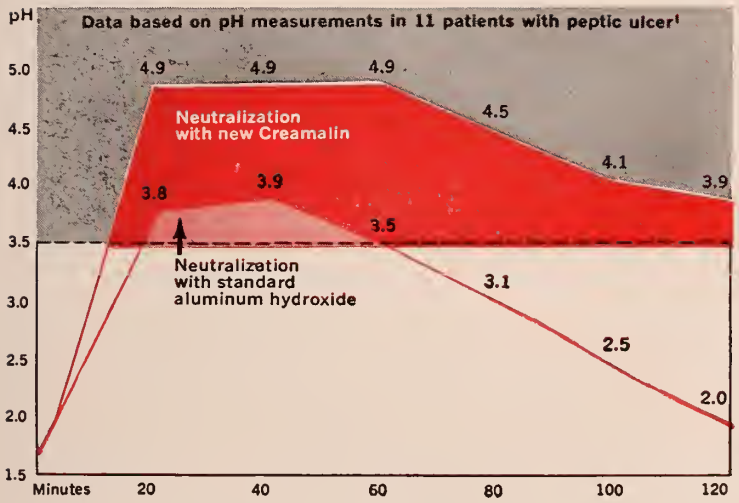
Phone for Delivery

HUmboldt 2-6007 in Newark

(or your local phone book for branch nearest you)

At the site of peptic ulcer

Following determination of basal secretion, intragastric pH was continuously determined by means of frequent readings over a two-hour period.



neutralization is much faster and twice as long with

New CREAMALIN® ANTACID TABLETS

New proof in vivo[1] of the much greater efficacy of new Creamalin tablets over standard aluminum hydroxide has now been obtained. Results of comparative tests on patients with peptic ulcer, measured by an intragastric pH electrode, show that new Creamalin neutralizes acid from 40 to 65 per cent faster than the standard preparation. This neutralization (pH 3.5 or above) is maintained for approximately one hour longer.

New Creamalin provides virtually the same effects as a liquid antacid[2] with the convenience of a tablet.

Nonconstipating and pleasant-tasting, new Creamalin antacid tablets will not produce "acid rebound" or alkalosis.

Each new Creamalin antacid tablet contains 320 mg. of specially processed, highly reactive, short polymer dried aluminum hydroxide gel (stabilized with hexitol) with 75 mg. of magnesium hydroxide. Minute particles of the powder offer a vastly increased surface area for quicker and more complete acid neutralization.

Dosage: Gastric hyperacidity — from 2 to 4 tablets as necessary. Peptic ulcer or gastritis — from 2 to 4 tablets every two to four hours. Tablets may be chewed, swallowed whole with water or milk, or allowed to dissolve in the mouth. **How supplied:** Bottles of 50, 100, 200 and 1000.

1. Data in the files of the Department of Medical Research, Winthrop Laboratories. 2. Hinkel, E. T., Jr.; Fisher, M. P., and Tainter, M. L.: **J. Am. Pharm. A.** (Scient. Ed.) 48:384, July, 1959.

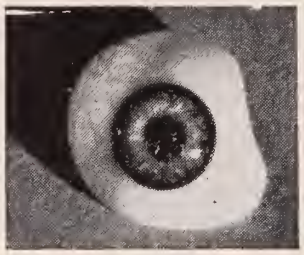
Winthrop LABORATORIES
New York 18, N. Y.

for peptic ulcer ■ gastritis ■ gastric hyperacidity

Specialists in ALL TYPES of Plastic and Glass

ARTIFICIAL HUMAN EYES Exclusively Made to Order in Our Own Laboratory

Doctors Are Invited to Visit



Referred Cases Carefully Attended

AND SATISFACTION GUARANTEED

EYES ALSO FITTED FROM STOCK

PLASTIC OR GLASS SELECTIONS SENT ON MEMORANDUM UPON REQUEST

Implants and Plastic Conformers in Stock

FRIED & KOHLER, INC.

665 FIFTH AVENUE
near 53rd Street

NEW YORK CITY, N. Y
Tel. ELdorado 5-1970

"PRESCRIBE WITH CONFIDENCE"

KATES BROS.

SCIENTIFIC SHOE FITTING

A Shoe and Last for Every Foot

SOLD ON Rx ONLY
CORRECTIVE FOOTWEAR
FOR MEN-WOMEN-CHILDREN

SOLD ON Rx ONLY
OUTFLAIR SHOES
FOR CLUB FEET

177A JEFFERSON AVE.
PASSAIC, N. J.

69 WESTWOOD AVE.
WESTWOOD, N. J.

202 MAIN ST.
HACKENSACK, N. J.

Dennis Brown Splints — in all sizes — carried in stock

the complaint: "nervous indigestion"

the diagnosis: any of several nonspecific and functional gastrointestinal disorders requiring relief of symptoms by sedative-antispasmodic action with concomitant digestive enzyme therapy.

the prescription: a new formulation incorporated in an enteric-coated tablet, providing the multiple actions of widely accepted Donnatal® and Entozyme.®

the dosage: two tablets three times a day, or as indicated.

in the gastric-soluble outer layer:

Hyoscyamine sulfate	0.0518 mg.
Atropine sulfate	0.0097 mg.
Hyoscine hydrobromide	0.0033 mg.
Phenobarbital (1/8 gr.)	8.1 mg.
Pepsin, N. F.	150 mg.

in the enteric-coated core:

Pancreatin, N. F.	300 mg.
Bile salts	150 mg.

antispasmodic • sedative • digestant

DONNAZYME®

A. H. ROBINS COMPANY, INCORPORATED • RICHMOND 20, VIRGINIA

more effective than salicylate alone in antirheumatic therapy

PABALATE®

COMBINING MUTUALLY SYNERGISTIC NON-STEROID ANTIRHEUMATICS

"superior to aspirin" — ". . . evidence seems to indicate that the concurrent administration of para-aminobenzoic and salicylic acid [as in Pabalate] produces a more uniformly sustained level for prolonged analgesia and, therefore, is superior to aspirin in the treatment of chronic rheumatic disorders."[1]

In each yellow enteric-coated PABALATE tablet:

Sodium salicylate (5 gr.) ..... 0.3 Gm.
Sodium para-aminobenzoate (5 gr.) ..... 0.3 Gm.
Ascorbic acid ..... 50.0 mg.

For the patient who should avoid sodium

PABALATE®-SODIUM FREE

Same formula as Pabalate, with sodium salts replaced by potassium salts (pink)

For the patient who requires steroids

PABALATE®-HC

Pabalate with Hydrocortisone

In each light blue enteric-coated PABALATE-HC tablet:

Hydrocortisone ..... 2.5 mg.
Potassium salicylate (5 gr.) ..... 0.3 Gm.
Potassium para-aminobenzoate (5 gr.) ..... 0.3 Gm.
Ascorbic acid ..... 50.0 mg.

1. Ford, R. A., and Blanchard, K.: Journal-Lancet 78:185, 1958.

A. H. ROBINS CO., INC., Richmond 20, Virginia

CLASSIFIED ADVERTISEMENTS

WANTS FOR SALE TO LET

SITUATIONS ETC.

Send replies to box number c/o **The Journal** P. O. Box 904, Trenton 5, N. J.

$3.00 for 25 words or less: additional words 5c each Forms close 15th of the Preceding Month.

ANESTHESIOLOGIST—Available in January, desires location in New Jersey, preferably northeastern area. Write Box RO, c/o THE JOURNAL.

GENERAL PRACTITIONER WANTED—Union County location. Well equipped office. Join two MD's in established practice. Please write Box CT, c/o THE JOURNAL.

INDUSTRIAL PHYSICIAN—Large Phila. industrial firm has immediate opening in its Medical Division for a physician to assist in the implementation of its Employe Medical Program. Headquarters in Phila. with some travel. Licensed or eligible for licensing in Penna. Send full details of education, experience, etc. to H. A. Smith, P. O. Box 7258, Phila. 1, Pa. All replies will be held in strictest confidence.

RESIDENTS WANTED: Resident house physicians for general voluntary 135-bed community hospital in Newark area. Must be state licensed or ECFMG certified. Salary open. Write Box WH, c/o THE JOURNAL.

FOR RENT—Five room professional office, fully equipped and furnished. Long established general practice. Fine Bayonne residential area. For information call FEderal 9-5596.

CLARK, N. J.—900 sq. ft., 4 rooms, plus private bathroom. Separate entrance in 3 suite building. One suite now occupied. Main street. Only one M.D. in this fastest growing town in Union County, population 12,000. Call FUlton 8-0011 or write Box AW, c/o THE JOURNAL.

OFFICE SPACE FOR RENT—Ideal for doctor or dentist. Three large rooms, three alcoves, one small dark room, large hallway, over 700 sq. feet floor space. All facilities. Located at 1849 Route #No 27 just off Plainfield Ave. in Edison, N. J. Call CHarter 9-1743.

PROF. SUITE AVAILABLE—Fort Lee, New Jersey. Five minutes from G. W. Bridge. New building in prime area. Dentist adjacent. Write Box MS, c/o THE JOURNAL.

FOR RENT—HOBOKEN—Office for one or two physicians; two consultation rooms mahogany panelled with built-in bookshelves and cabinets; two examining rooms with built-in sinks, formica counters, glassed-wall cabinets; bath and stall shower; reception room with hall receptionist desk; quiet residential neighborhood; leaving for specialty. For information call P. Giordano, OLdfield 6-2854.

UNUSUAL OPPORTUNITY—Professional Bldg., Montclair, New Jersey. Every advantage. Very low rental. Dr. Mearin—PI, 4-5657.

PLAINFIELD, N. J., 1310 West 7th St.—Two suites available, newly built professional building. Wood panelled waiting room, nurses' station, 3 examination rooms -one suite, and 2 examination rooms the other suite. Private lavatories, central heating and air conditioning, on site parking. Rent reasonable. Call WAverly 6-3238. One suite now occupied by dentist.

FOR SALE—Beautiful Haddonfield, New Jersey. 8 miles to Philadelphia! New listing! This impressive 2½ story residence on Kings Highway West is ideal for your home and office. 5 large rooms on the first floor including a dream kitchen. 4 bedrooms on 2nd floor. 3 finished rooms on 3rd floor. THREE BATHS AND TWO POWDER ROOMS. The panelled rooms in the basement will add pleasure to family living. The owner is asking $38,500. Pictures upon request. FOX & LAZO, 70 Tanner Street, Haddonfield, New Jersey. HAzel 8-2600.

FOR SALE—Luxurious 12 room home, 3 baths. Doctor's office and residence combined. Finest residential and professional location. Dr. Szafir, 177 High St., Perth Amboy, New Jersey.

(Continued on following page)

CLASSIFIED ADVERTISEMENTS

(Continued from preceding page)

HOME AND OFFICE FOR SALE—Retiring. Good terms, adjoining Newark, 10 miles from New York, large fully equipped office including x-ray; also room for dentist. Air conditioned. Two separate heating units. Elegant living quarters: 28' living room, 17' dining room, 3 bedrooms, wall-to-wall carpeting, eat-in kitchen, large expandable attic, full basement, 2-car garage. Contact: Edmund Lewandowski, M.D., 2 Smalley Terrace, Irvington, New Jersey. (population 75,000) ESsex 3-4648.

PERTH AMBOY—Practice for sale due to sudden death of prominent EENT specialist. Established more than 40 years: gross over $60,000.00: same office available; 4 examining rooms; complete modern equipment. Excellent hospital facilities. Replacement urgently needed in rapidly expanding industrial area. Terms of sale open to negotiation. Contact: Alfred D. Antonio, Attorney for Estate, 175 Smith Street, Perth Amboy.

FOR SALE—Princeton: 10-room, 2½-bath, home-office combination. All-electric kitchen. Completely landscaped. Near shopping center. Parking area for 10 cars available. Write Box SU, c/o THE JOURNAL.

FOR SALE—South Jersey shore area. Will sacrifice home, office, tremendous general practice for real estate value. Leaving for residency. High income assured. Will finance. Write Box FH, c/o THE JOURNAL.

FOR SALE—Two-year old, 6-room equipped office and 7-room house combination of deceased doctor. On Doctors' Row, 5 miles to Geo. Wash. Bridge. Write Mrs. Walter J. Farr, 951 Queen Anne Rd., Teaneck, New Jersey, or phone TE 6-3211.

TENAFLY, N. J.—House and office, separate entrances, corner location, near shopping, buses and schools. Practice optional. Two-story, 8 rooms, 220 volt wiring, air conditioners. $28,500. LOwell 7-0187.

PRINCETON AVE., TRENTON—Property includes 3-bedroom house with 18x30 living room, large dining room, modern kitchen, enclosed sun porch and modern physician's office with private entrance, reception room, office, examining room and lavatory. Two-car garage. Available immediately. Walter F. Smith & Company, 145 Academy Street, Trenton. OWen 5-3441.

massages pain away in musculoskeletal involvements[1]

GER-O-FOAM
(aerosol foam)

relieves pain, spasm; improves function increases tolerance to exercise

GER-O-FOAM's exclusive formula provides for the first time deeply absorbed analgesic-anesthetic agents in aerosol form — to permeate and anesthetize sensory nerve endings.

Relief in minutes, lasting for hours in . . . rheumatoid arthritis, osteoarthritis, muscle sprain, fibromyositis, low back pain . . . even in chronic intractable cases.

GER-O-FOAM combines: Methyl salicylate 30%, benzocaine 3%, in a neutralized emulsion base, permitting fast penetration through the stratum corneum.

Sample and reprint from

GERIATRIC PHARMACEUTICAL CORP.
Bellerose, New York

Pioneers in Geriatric Research

1. Gordon, E. E. and Haas, A.: Industrial Medicine & Surgery 28:217, 1959.

contain the bacteria-prone cold

TAIN

(Triacetyloleandomycin, Triaminic® and Calurin®)

inner protection with...

safe antibiosis

Triacetyloleandomycin, equivalent to oleandomycin 125 mg. This is the URI antibiotic, clinically effective against certain antibiotic-resistant organisms.

fast decongestion

Triaminic®, 25 mg., three active components stop running noses. Relief starts in minutes, lasts for hours.

well-tolerated analgesia

Calurin®, calcium acetylsalicylate carbamide equivalent to aspirin 300 mg. This is the freely-soluble calcium aspirin that minimizes local irritation, chemical erosion, gastric damage. High, fast blood levels.

TAIN brings quick, symptomatic relief of the common cold (malaise, headache, muscular cramps, aches and pains) especially when susceptible organisms are likely to cause secondary infection. Usual adult dose is 2 Inlay-Tabs, q.i.d. In bottles of 50. ℞ only. Remember, to contain the bacteria-prone cold...TAIN.

SMITH-DORSEY · Lincoln, Nebraska
a division of The Wander Company

. . . MALNUTRITION OR
LEG CRAMPS DURING PREGNANCY?

OUTMODED AS GODEY'S FASHIONS!

℞ NEW

PRENALIN-O®

PRENATAL SUPPLEMENT

1. Oyster Shell Calcium - Phosphorus Free!
2. New Form of Iron!
3. Dry Filled Capsule - Sure, Quick Absorption!
4. Economical Once-A-Day Dosage!
5. Wider Range Nutritional Support!
6. Relieves Troublesome Leg Cramps!

EACH dry filled capsule (lavender and white) provides:

Ferrous Fumarate (Iron)	150 mg	Vitamin B-12 (Cobalamin conc. NF)	2 mcg.
Deep sea oyster shell (Calcium)	600 mg	Folic Acid	0.25 mg
Vitamin C	50 mg	Niacinamide	10 mg.
Vitamin A	4000 USP Units	Vitamin K (Menadione)	0.25 mg.
Vitamin D	400 USP Units	Rutin	10 mg.
Vitamin B-1	2 mg.	Sodium Molybdate	3 mg.
Vitamin B-2	2 mg	Fluorine (Calcium Fluoride)	0.25 mg.
Vitamin B-6	0.8 mg	Iodine (Potassium Iodide)	0.15 mg.

SAMPLES ON REQUEST

TUTAG

S. J. TUTAG & CO.
DETROIT 34, MICHIGAN

RADON • RADIUM

SEEDS • IMPLANTERS • CERVICAL APPLICATORS

THE RADIUM EMANATION CORPORATION

GRAYBAR BUILDING • NEW YORK 17, N. Y.

Wire or Phone MUrray Hill 3-8636 Collect

HALL-BROOKE HOSPITAL

An Active Treatment Hospital, located one hour from New York

Accredited by: The Central Inspection Board of the American Psychiatric Association
The Joint Commission on Accreditation of Hospitals

HALL-BROOKE, GREENS FARMS, BOX 31, CONN.

Telephone: WESTPORT CAPITAL 7-1251

George S. Hughes, M.D.
Leo H. Berman, M.D.
Albert M. Moss, M.D.
Louis J. Micheels, M.D.
Robert Isenman, M.D.
John D. Marshall, Jr., M.D.
Edward M. Keelan, M.D.
Peter P. Barbara, Ph.D.

FAIR OAKS

SUMMIT, NEW JERSEY

An 80 bed private psychiatric hospital for intensive treatment specializing in the latest therapeutic techniques plus electroshock and insulin coma therapy. Write

THOMAS P. PROUT, Jr.
Administrator

OSCAR ROZETT, M.D.
Medical Director

P. SINGER, M.D.
E. SOKAL, M.D.
ELIZABETH ROZSA, M.D.
M. E. NEUMAN, M.D.
Associates

Tel. CRestview 7-0143

The Glenwood Sanitarium

LICENSED FOR THE CARE AND TREATMENT OF

NERVOUS AND MENTAL DISORDERS
ALCOHOLISM AND DRUG ADDICTION

Homelike surroundings, good nursing psychiatric treatment, including shock therapy and excellent food.

R. GRANT BARRY, M.D.

2301 NOTTINGHAM WAY TRENTON, N. J.
JUniper 7-1210

PHONE
CH. 2-2330

for well trained highly qualified personnel

MEDICAL
OFFICE ASSISTANTS OR SECRETARIES

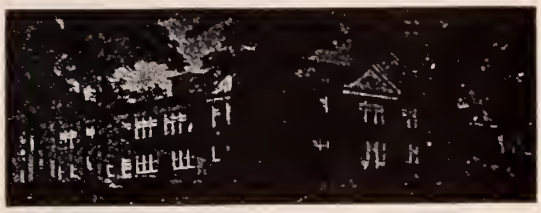
Co-Ed (Founded 1936)

N. Y. State Licensed Day-Eve. Courses
Trained by Physicians for Physicians

Eastern

request Free Cat. 7

SCHOOL FOR PHYSICIANS' AIDES
85 Fifth Ave. (16th St.) New York 3, N. Y.
affiliated with CARNEGIE INSTITUTE. INC. *Cleveland, O.*



The Children's Country Home

An accredited 54-bed specialized hospital for handicapped children. Especially equipped for care of cardiac pre- and postoperative cases, cerebral palsy, polio, congenital defects, rheumatoid arthritis, Legg-Perthes' diseases and other orthopedic conditions. Our services include physical therapy and pool treatments, x-ray, occupational and speech therapy. Regular schooling is provided.

The referring physician may continue to prescribe treatment or may transfer responsibility to our staff.

* * *

New Providence Road
Westfield, New Jersey

REPRESENTATIVE FUNERAL DIRECTORS

OF THE STATE OF NEW JERSEY

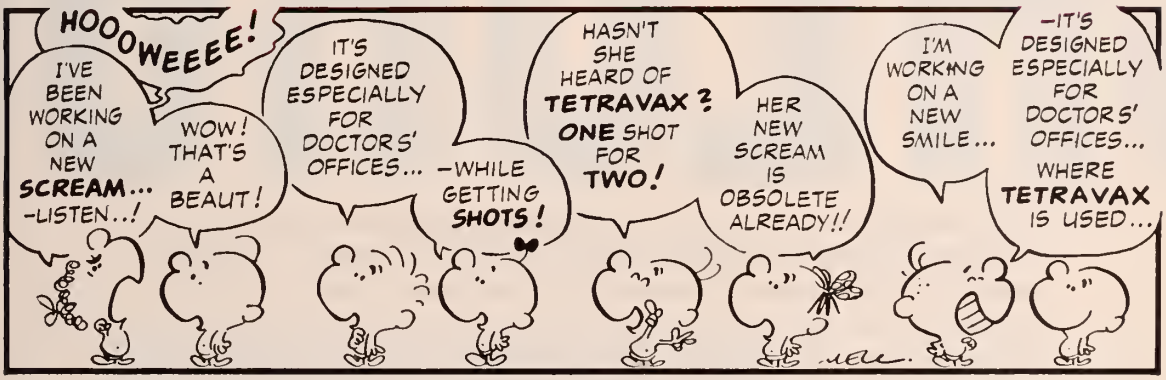
Special and Dependable Service Day and Night. Special Attention Given to Hospital Calls, Train and Express Shipments.

PLACE	NAME AND ADDRESS	TELEPHONE
ADELPHIA	C. H. T. Clayton & Son	FReehold 8-0583
ASBURY PARK	Ely Funeral Home, 514 Second Ave.	PRospect 5-0567
ASBURY PARK	Matthews, Francioni & Taylor Funeral Home, 704 7th Ave.	PRospect 5-0021
ATLANTIC CITY	H. M. Gormley Funeral Home, 911 Pacific Ave.	ATlantic City 4-3188
BERGENFIELD	Riewerts Memorial Home, 187 S. Washington Ave.	DUmont 4-0700
BLOOMFIELD	The Howard W. Kopf Funeral Home, 401 Franklin St.	PIlgrim 3-1396
BLOOMFIELD	George Van Tassel's Community Funeral Home	PIlgrim 3-1234
BOONTON	Lewis & Carey Incorporated, 312 W. Main St.	DEerfield 4-0842
CAMDEN	F. T. Walker & E. E. Walker Fun. Home, 743 Chestnut St.	WOodlawn 3-2581
CHATHAM	Wm. A. Bradley Funeral Home, 345 Main St.	MErcury 5-2428
COLLINGSWOOD	Schaffhauser Funeral Home, 983 Haddon Ave.	ULysses 4-5454
CRANBURY	A. S. Cole Son & Co., Main St.	EXport 5-0770
ELIZABETH	Aug. F. Schmidt & Son, 139 Westfield Ave.	ELIzabeth 2-2268
ENGLEWOOD	Greenleaf Funeral Home, Inc., 108 W. Palisade Ave.	ENglewood 3-0416
FREEHOLD	Higgins Memorial Home, 20 Center St.	HOpkins 2-0895
HOBOKEN	Failla Memorial Home, 533 Willow Ave.	HOboken 3-0082
JERSEY CITY	Patrick J. Conte Funeral Home, 36 Tuers Ave.	HE 5-6451, DE 3-9259
JERSEY CITY	McLaughlin Funeral Home, 591 Jersey Ave.	OLdfield 3-2266
JERSEY CITY	Donald F. Wood Funeral Residence, 582 Bergen Ave.	DElaware 3-6480
LINDEN	Don McCracken Funeral Home, 2124 St. Georges Ave., E.	ELizabeth 2-3270
LITTLE FALLS	Norman A. Parker Funeral Home, 47 Main St.	CLifford 6-4700
METUCHEN	Runyon Mortuary, 568 Middlesex Ave.	LIberty 8-0149
MOORESTOWN	Harvey H. Brown Funeral Home, 10. W. Main St.	BElmont 5-5555
MORRISTOWN	Raymond A. Lanterman & Son, 126 South St.	JEfferson 9-2880
NEWARK	Barrish Funeral Home, 684 Clinton Ave.	ESsex 3-1551—9179
NEWARK	Beckett's Funeral Home, 120 W. Market St.	MItchell 2-4068
NEWARK	James E. Churchman Service, 132 Clinton Ave.	BIgelow 8-1672
NEWARK	Peoples Burial Co., 84 Broad St.	HUmboldt 2-0707
NEWFOUNDLAND	Stickle Funeral Home, Union Valley Road	OXbow 7-8141
PARAMUS	Vander Plaat Memorial Home, S-113 Fairview Ave.	DIamond 2-3688
PATERSON	DeLuccia Funeral Home, 111 Belmont Ave.	LAmbert 3-6666
PATERSON	R. Charles D. Legg & Sons, 384 Broadway	SHerwood 2-2385
PATERSON	Moore's Home for Funerals, 384 Totowa Ave.	ARmory 8-1500
PATERSON	Scanlan Funeral Homes, 421 Twelfth Ave. at E. 28th St.	SHerwood 2-6433
PATERSON	Vermeulen Memorial Funeral Home, 131 Haledon Ave.	MUlberry 4-3974
POINT PLEASANT	George W. Whateley Funeral Home, 1105 Arnold Ave.	TWinbrook 9-0792
RAHWAY	Lehrer Funeral Home, 275 W. Milton Ave.	FUlton 8-1874
RAMSEY	The Harold Van Emburgh Funeral Home, Inc.	DAvis 7-0030
RIDGEWOOD	C. C. Van Emburgh, Inc., 306 E. Ridgewood Ave.	GIlbert 5-0344
RIVERDALE	George E. Richards, Newark Turnpike	TEmple 5-0164
SOUTH AMBOY	The Gundrum Service, 237 Bordentown Ave.	PArkway 1-0241
SOUTH RIVER	Rezem Funeral Home, 190 Main St.	SOuth RIver 6-1191
SPOTSWOOD	Hulse Funeral Home, 455 Main St.	SOuth RIver 6-3041
TRENTON	Daniel Brenna Funeral Home, 340 Hamilton Ave.	EXport 3-2857
TRENTON	Ivins & Taylor, Inc., 77 Prospect St.	EXport 4-5186
TRENTON	Elmer A. Kemp Funeral Home, 260 White Horse Ave.	EXport 4-5094
TRENTON	Poulson & Van Hise, 408 Bellevue Ave.	EXPORT 6-8168
TRENTON	Saul Funeral Homes	JUniper 7-8221 and JUniper 7-0170
WEST ENGLEWOOD	Clifford H. Peinecke Funeral Home, 1312 Teaneck Rd.	TEaneck 7-2332

FOR SIMULTANEOUS IMMUNIZATION AGAINST 4 DISEASES:

Poliomyelitis-Diphtheria-Pertussis-Tetanus

PEDI-ANTICS



TETRAVAX®

DIPHTHERIA AND TETANUS TOXOIDS WITH PERTUSSIS AND POLIOMYELITIS VACCINES

now you can immunize against more diseases...with fewer injections

Dose: 1 cc.
Supplied: 9 cc. vials in *clear plastic* cartons. Package circular and material in vial can be examined without damaging carton. Expiration date is on vial for checking even if carton is discarded.

For additional information, write Professional Services, Merck Sharp & Dohme, West Point, Pa.

TETRAVAX IS A TRADEMARK OF MERCK & CO., INC.

MERCK SHARP & DOHME, DIVISION OF MERCK & CO., INC., PHILADELPHIA 1, PA.

4,860 CULTURES... 74% SENSITIVE TO

CHLORO

In a study of the sensitivity of various clinically important bacteria to six common antibacterial substances, Goodier and Parry[1] report "...a greater proportion of the individual strains within the various genera sensitive to chloramphenicol."

Numerous other studies draw attention to the continuing sensitivity of stubborn pathogens to CHLOROMYCETIN.[2-8] For example, Modarress and co-workers observe: "The versatile chloramphenicol was useful each year."[2] Petersdorf and associates[3] state: "There has been no increase in resistance to chloramphenicol...during the past three years."

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in various forms, including Kapseals® of 250 mg., in bottles of 16 and 100.

CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

References: (1) Goodier, T. E. W., & Parry, W. R.: *Lancet* 1:356, 1959. (2) Modarress, Y.; Ryan, R. J., & Francis, Sr. C.: *J. M. Soc. New Jersey* 57:168, 1960. (3) Petersdorf, R. G., *et al.*: *Arch. Int. Med.* 105:398, 1960. (4) Rebhan, A. W., & Edwards, H. E.: *Canad. M.A.J.* 82:513, 1960. (5) Bauer, A. W.; Perry, D. M., & Kirby, W. M. M.: *J.A.M.A.* 173:475, 1960. (6) Olarte, J., & de la Torre, J. A.: *Am. J. Trop. Med.* 8:324, 1959. (7) Berle, B. B., *et al.*: *New York J. Med.* 59:2383, 1959. (8) Fisher, M. W.: *Arch. Int. Med.* 105:413, 1960.

09860

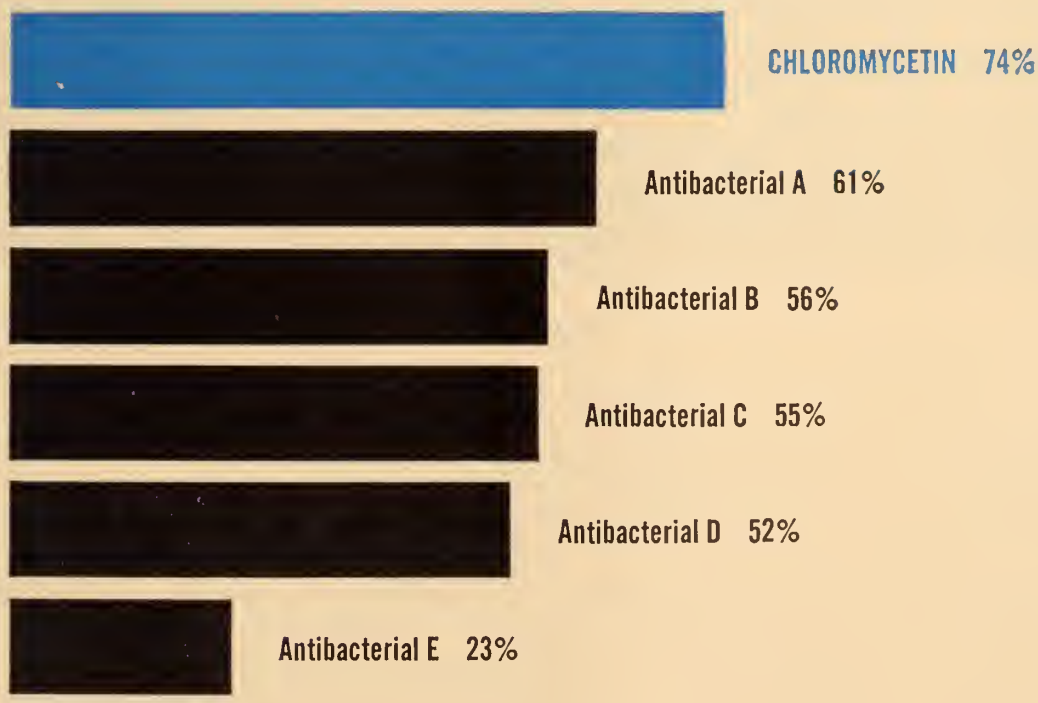
PARKE, DAVIS & COMPANY
Detroit 32, Michigan

PARKE-DAVIS

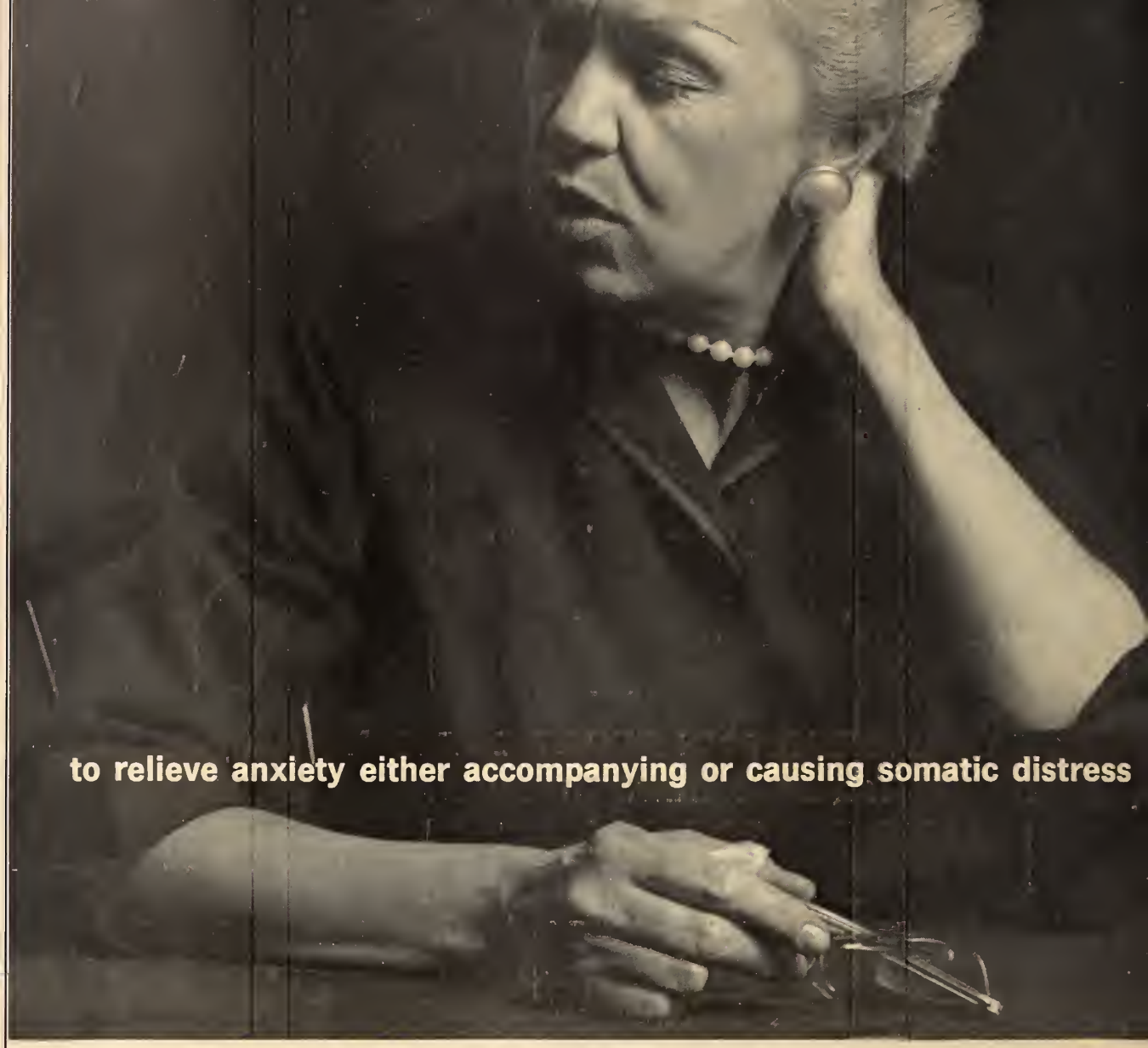
YCETIN®

(chloramphenicol, Parke-Davis)

IN VITRO SENSITIVITY OF 4,860 GRAM-POSITIVE AND GRAM-NEGATIVE PATHOGENS TO CHLOROMYCETIN AND TO FIVE OTHER ANTIBACTERIALS*



*Adapted from Goodier & Parry[1]



advantages you can expect to see with Stelazine®

brand of trifluoperazine

- **Prompt control of the underlying anxiety.** Beneficial effects are often seen within 24-48 hours.
- **Amelioration of somatic symptoms.** Marx[1] reported from his study of 43 office patients that 'Stelazine' "appeared to be effective for patients whose anxiety was associated with organic—as well as functional disorders."
- **Freedom from lethargy and drowsiness.** Winkelman[2] observed that 'Stelazine' "produces a state approaching ataraxia without sedation which is unattainable with currently available neuroleptic agents; its freedom from lethargy and drowsiness makes ['Stelazine'] extremely well accepted by patients."

Optimal dosage: 2-4 mg. daily. Available as 1 mg. and 2 mg. tablets, in bottles of 50 and 500.

N.B.: For further information on dosage, side effects, cautions and contraindications, see available comprehensive literature, *Physicians' Desk Reference*, or your S.K.F. representative. Full information is also on file with your pharmacist.

1. Marx, F.J., in *Trifluoperazine: Further Clinical and Laboratory Studies*, Philadelphia, Lea & Febiger, 1959, p. 89.
2. Winkelman, N.W., Jr.: *ibid.*, p. 78.

SMITH KLINE & FRENCH

INDEX NUMBER

THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

Entered as second-class matter September 5, 1906, at the post office at Orange, New Jersey, under Act of March 3, 1879
Second Class Postage Paid at Orange, N. J.

VOL. 57, NO. 12 DECEMBER, 1960 Subscriptions, $3.00 per Year
Single Copies, 30 Cents

THE N.Y. ACADEMY OF MEDICINE
DEC 19 1960
LIBRARY

CONTENTS—Pages 675 to 738

EDITORIALS— Page

The Concept of "Normal" 675
Influenza is Still a Problem 676

ORIGINAL ARTICLES—

Coronary Artery Disease in a Rapidly Growing Suburb—Richard E. Gordon, M.D., *et al.*, Englewood, N. J. 677

Skin Tumor as the Cause of Nodular Chest Density—E. P. Gelvin, M.D., Whippany, N. J. 684

Sprains and Strains of the Knee Joint—William G. Kuhn, Jr., M.D., New Brunswick, N. J. 686

Renal Injury—George W. Irmisch, M.D., Trenton, N. J. 689

Pre-anesthetic Medication in Pediatric Patients—R. A. Vlatten, M.D., Newark, N. J. 692

Prolonged Treatment of Hypertension with Rauwolfia—G. Barton Barlow, M.D., Englewood, N. J. 695

ORIGINAL ARTICLES— Page

Role of the Team Physician in Athletic Injuries—William J. Farley, M.D., Nutley, N. J. 700

STATE ACTIVITIES—

Documentary Medical Film Available 685
Industrial Medicine Fellowships 688
Trustees' Meeting: September 18, 1960 706
Liability Insurance for Government Employees 710
Medical Military History Available 721

OBITUARIES 711

SYMPOSIUM ON THE PROBLEMS OF THE AGED 712

ANNOUNCEMENTS 722

COUNTY SOCIETY REPORTS 723

BOOK REVIEWS 727

ANNUAL INDEX 1960 728

NTA ABSTRACTS 737

Roster of Officers and Committee Chairmen, Advertising Page 3A

Place of Publication, Printing and Mailing, 116-118 Lincoln Ave., Orange, N. J.

Editorial and Executive Offices of the Society 315 West State St., Trenton 8, N. J.

Address all communications FOR PUBLICATION to editorial office at P.O. Box 904, Trenton 5, N. J.

Telephone EXport 4-3154

Published Monthly Since 1904

Acceptance for mailing at special rate of postage provided for in Sec. 1103, Act of Oct. 3, 1917, authorized July 29, 1918.

Copyright 1960 by
The Medical Society of New Jersey

THE NEW LIFE INSURANCE PLAN

officially endorsed by

THE MEDICAL SOCIETY OF NEW JERSEY

WHAT YOUR PLAN OFFERS

FIRST UNIT OF $10,000 of 5-year renewable and convertible term life insurance issued on a short health statement WITHOUT MEDICAL EXAMINATION, but subject to the company's underwriting rules of selection, PLUS as much as $40,000 additional life insurance subject to a physical examination.

PREMIUMS DO NOT CHANGE during each 5-year period.

RATES LOWER THAN you can obtain individually and guaranteed for the life of your policy with premiums reducible by dividends as declared by the company.

COVERAGE GUARANTEED non-cancellable even if you retire or move.

GUARANTEED RIGHT TO CONVERT to any permanent plan AT ANY TIME without evidence of insurability.

DOUBLE INDEMNITY for accidental death included without extra charge.

WAIVER OF PREMIUM for total and permanent disability prior to age 60 without extra charge.

MORE THAN 1,700 MEMBERS OF THE STATE SOCIETY ARE PRESENTLY INSURED UNDER THIS PROGRAM.

WHAT YOUR PLAN COSTS FOR EACH $10,000 UNIT

(Your age at the beginning of each five year term determines the premiums for each year during that term.)

YOUR AGE (nearest birthday)	ANNUAL	SEMI-ANNUAL
29 and under	$ 50.00	$ 25.50
30	60.00	30.60
31	63.00	32.10
32	65.00	33.20
33	67.00	34.20
34	70.00	35.70
35	73.00	37.20
36	77.00	39.30
37	80.00	40.80
38	83.00	42.30
39	87.00	44.40
40	90.00	45.90
41	93.00	47.40
42	96.00	49.00
43	99.00	50.50
44	103.00	52.50
45	107.00	54.60
46	113.00	57.60
47	124.00	63.20
48	136.00	69.40
49	148.00	75.50
50	160.00	81.60
51	175.00	89.30
52	185.00	94.40
53	195.00	99.50
54	205.00	104.60
55	230.00	117.30
56	250.00	127.50
57	265.00	135.20
58	280.00	142.80
59	295.00	150.50
60	315.00	160.70
61	330.00	168.30
62	345.00	176.00
63	360.00	183.60
64	375.00	191.30
65	405.00	206.60

Issued and renewed for successive 5 year terms beginning before 65th birthday. Insurance coverage then continuable through conversion.

Administered by:

E. & W. BLANKSTEEN AGENCY, INC.

75 Montgomery St., Jersey City 2, N. J. • Telephone: Delaware 3-4340

Underwritten by Nationwide Life Insurance Company of Columbus, Ohio

Highest rating in Best's Insurance Reports with more than 1½ billions of life insurance in force.

THE MEDICAL SOCIETY OF NEW JERSEY

Founded July 23, 1766

PLACE OF PUBLICATION, PRINTING AND MAILING, 116 LINCOLN AVE., ORANGE, N. J.

EXECUTIVE AND EDITORIAL OFFICES, 315 WEST STATE STREET, TRENTON 8, N. J. Tel. EXport 4-3154

(MAILING ADDRESS: P.O. BOX 904, TRENTON 5, N. J.)

Mr. Richard I. Nevin, *Executive Officer* ..... Trenton
Mrs. Edith L. Madden, *Administrative Secretary and Convention Manager* ..... Trenton
Henry A. Davidson, *Editor* ..... Cedar Grove
Mrs. Miriam N. Armstrong, *Assistant Editor* ..... Trenton

OFFICERS

President, Jesse McCall ..... Newton
President-Elect, Ralph M. L. Buchanan ..... Phillipsburg
First Vice-President, Louis S. Wegryn ..... Elizabeth
Second Vice-President, Carl N. Ware ..... Shiloh
Secretary, Marcus H. Greifinger ..... Newark
Treasurer, Daniel F. Featherston ..... Asbury Park

TRUSTEES

Luke A. Mulligan, *Chairman* (1962) ..... Leonia
Jerome G. Kaufman, *Secretary* (1961) ..... Newark
Jesse McCall ..... Newton
Ralph M. L. Buchanan ..... Phillipsburg
Louis S. Wegryn ..... Elizabeth
Carl N. Ware ..... Shiloh
Marcus H. Greifinger ..... Newark
Daniel F. Featherston ..... Asbury Park
F. Clyde Bowers ..... Mendham
David B. Allman (1962) ..... Atlantic City
John J. Bedrick (1963) ..... Bayonne
Nicholas A. Bertha (1962) ..... Wharton
C. Byron Blaisdell (1961) ..... Asbury Park
Louis K. Collins (1961) ..... Glassboro
Lloyd A. Hamilton (1962) ..... Lambertville
Frank J. Hughes (1963) ..... Gloucester
Joseph R. Jehl (1963) ..... Clifton
Samuel J. Lloyd (1963) ..... Trenton

COUNCILORS

First District (Union, Warren, Morris and Essex Counties) ..... Emanuel M. Satulsky, Elizabeth (1963)
Second District (Sussex, Bergen, Hudson and Passaic Counties) ..... John L. Olpp, Englewood (1962)
Third District (Mercer, Middlesex, Somerset and Hunterdon Counties) ..... Charles H. Calvin, Perth Amboy (1961)
Fourth District (Camden, Burlington, Ocean and Monmouth Counties) ..... E. Vernon Davis, Moorestown (1963)
Fifth District (Cape May, Cumberland, Atlantic, Gloucester and Salem Counties) ..... Isaac N. Patterson, Westville (1962)

DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Delegates

C. Byron Blaisdell (1960) ..... Asbury Park
William F. Costello (1961) ..... Dover
Aldrich C. Crowe (1961 ..... Ocean City
J. Wallace Hurff (1960) ..... Newark
L. Samuel Sica (1960) ..... Trenton
Elmer P. Weigel (1960) ..... Plainfield

Alternates

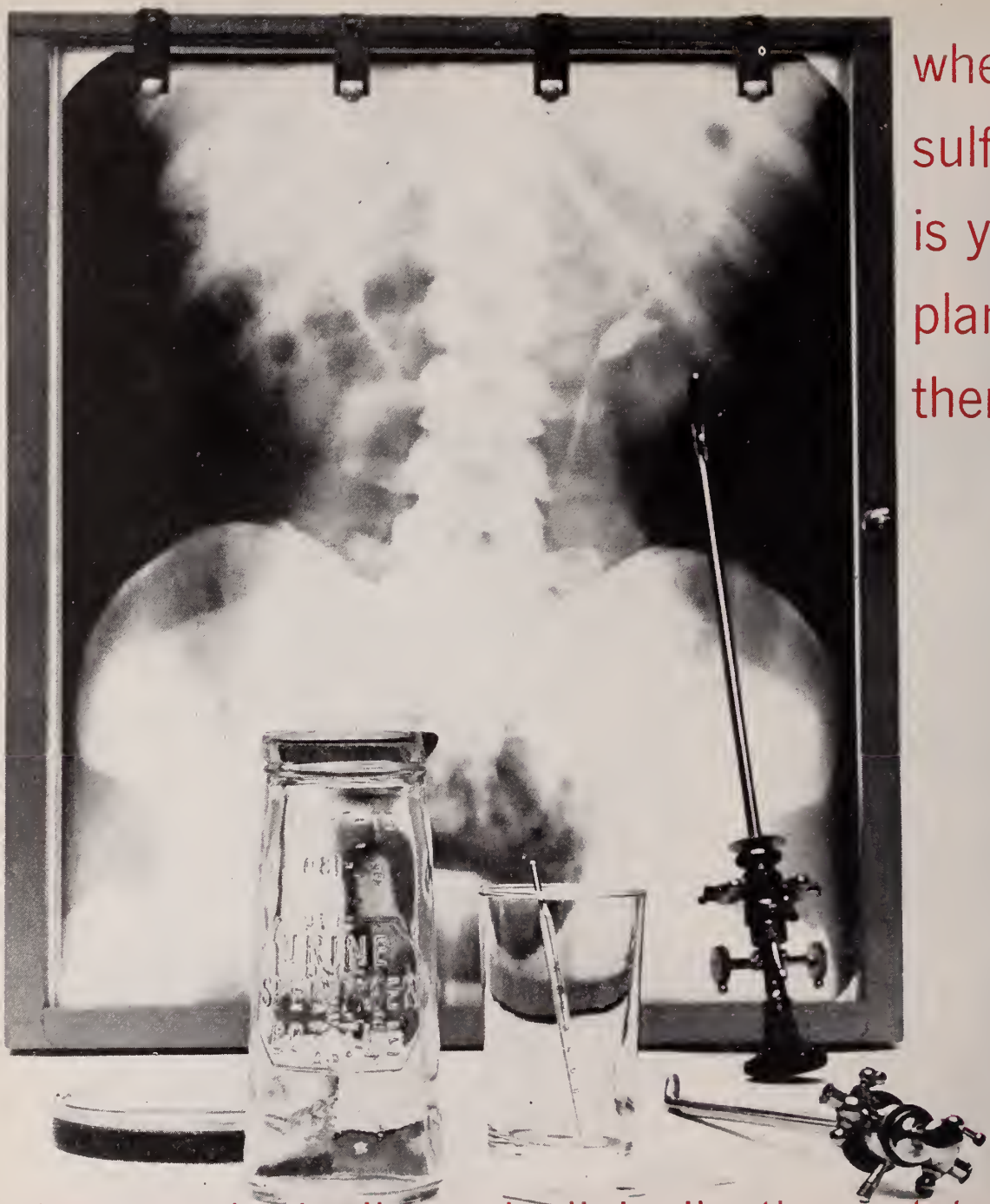
Ralph M. L. Buchanan (1960) ..... Phillipsburg
Joseph P. Donnelly (1961) ..... Jersey City
Elton W. Lance (1961) ..... Rahway
Jesse McCall (1960) ..... Newton
Herschel Pettit (1960) ..... Ocean City
John H. Rowland (1960) ..... New Brunswick

DELEGATES TO OTHER STATES

New York—William F. Costello (1961) ..... Dover
Connecticut—Lloyd A. Hamilton (1961) ..... Lambertville
New York—Levi M. Walker (1961) ..... Atlantic City
Connecticut—S. Eugene Dalton (1961) ..... Ventnor

COMMITTEE CHAIRMEN — 1960-61

Annual Meeting ..... Jerome G. Kaufman, Newark
..... Vice-Chairman—Edward E. P. Seidmon, Plainfield
Cancer Control ..... John L. Olpp, Englewood
Child Health ..... Robert E. Jennings, South Orange
Chronically Ill and Aging ..... William H. Hahn, Newark
Constitution and Bylaws ..... Louis F. Albright, Spring Lake
..... Vice-Chairman—Joseph M. Gannon, Plainfield
Credentials ..... M. H. Greifinger, Newark
..... Vice-Chairman—Eugene J. Tyrrell, Perth Amboy
Disaster Medical Services ..... R. Winfield Betts, Medford
Finance and Budget ..... David B. Allman, Atlantic City
..... Vice-Chairman—Carl N. Ware, Shiloh
Hearing and Speech ..... S. Eugene Dalton, Ventnor
Honorary Membership ..... Aldrich C. Crowe, Ocean City
..... Vice-Chairman—Royal A. Schaaf, Califon
Industrial Health ..... Willis B. Mitchell, Toms River
Legislation ..... C. Byron Blaisdell, Asbury Park
..... Vice-Chairman—A. Guy Campo, Westville
Maternal and Infant Welfare ..... John D. Preece, Trenton
Medical Defense and Insurance ..... Daniel F. Featherston, Asbury Park
..... Vice-Chairman—Benjamin F. Slobodien, Perth Amboy
Medical Education ..... Sherman Garrison, Jr., Bridgeton
..... Vice-Chairman—Morris H. Saffron, Passaic
Medical Services ..... Irving Klompus, Bound Brook
..... Vice-Chairman—Nicholas E. Marchione, Vineland
Medical Student Loan Fund ..... Luke A. Mulligan, Leonia
..... Vice-Chairman—Vincent P. Butler, Jersey City
Mental Health ..... John J. Mackin, Jersey City
Physicians Placement Service ..... Samuel J. Lloyd, Trenton
Publication ..... Fred B. Rogers, Trenton
..... Vice-Chairman—C. Spencer Davison, Salem
Public Health ..... Robert S. Garber, Belle Mead
..... Vice-Chairman—John B. Fuhrmann, Flemington
Public Relations ..... John F. Kustrup, Trenton
..... Vice-Chairman—John J. Torppey, Newark
Rehabilitation ..... Elmer J. Elias, Trenton
Scientific Exhibit ..... Milton Ackerman, Atlantic City
Scientific Program ..... Edward E. P. Seidmon, Plainfield
Traffic Safety ..... A. M. K. Maldeis, Camden
Vision ..... Samuel M. Diskan, Atlantic City
Woman's Auxiliary ..... Lewis C. Fritts, Somerville
..... Vice-Chairman—A. Guy Campo, Westville
Workmen's Compensation ..... Joseph A. Lepree, Elizabeth



when sulfa is your plan of therapy.

pharmacologically and clinically the outstanding

Rapid peak attainment — for early control — KYNEX® Sulfamethoxypyridazine reaches peak plasma levels in 1 to 2 hours[1,2] . . . or approximately one-half the time of other once-a-day sulfas.[2] Uninterrupted control is then sustained over 24 hours with the single daily dose . . . through slow excretion without renal alteration.

High free levels — for dependable control — More efficient absorption delivers a higher percentage of sulfamethoxypyridazine — averaging 20 per cent greater at respective peaks than glucuronide-conversion sulfas.[2] Of the total circulating levels, 95 per cent remains in the fully active, unconjugated form even after 24 hours.[3]

Extremely low toxicity[4] . . . only 2.7 per cent incidence in recommended dosage — Typical of KYNEX relative safety, toxicity studies[5] in 223 patients showed TOTAL side effects (both subjective and objective) in only six cases, all temporary and rapidly reversed. Another evaluation[4] in 110 patients confirmed the near-absence of reactions when given at the recommended dosage. High solubility of both free and conjugated product[6] obviates renal complications. No crystalluria has been reported.

Successful against these organisms: streptococci, staphylococci, E. coli, A. aerogenes, paracolon bacillus, Gram-negative rods, pneumococci, diphtheroids, Gram-positive cocci and others.

1. Boger, W. P.; Strickland, C. S., and Gylfe, J. M.: Antibiotic Med. & Clin. Ther. 3:378, (Nov.) 1956. 2. Boger, W. P.: Antibiotics Annual 1958-1959, New York, Medical Encyclopedia, Inc., 1959, p. 48. 3. Sheth, U. K.; Kulkarni, B. S., and Kamath, P. G.: Antibiotic Med. & Clin Ther. 5:604 (Oct.) 1958. 4. Vinnicombe, J.: Ibid. 5:474 (July) 1958. 5. Anderson, P. C., and Wissinger, H. A.: U. S. Armed Forces M. J. 10:105 (Sept.) 1959. 6. Roepke, R. R.; Maren, T. H., and Mayer, E.: Ann. New York Acad. Sc. 60:457 (Oct.) 1957.

KYNEX is your drug of choice

once-a-day sulfa . . .

NOTE: Investigators note a tendency of some patients to misinterpret dosage instructions and take KYNEX on the familiar q.i.d. schedule. Since one KYNEX tablet is equivalent to eight to twelve tablets of other sulfas, even moderate overdosage may produce side effects. Thus, the single dose schedule must be stressed to the patient.

KYNEX Tablets, 0.5 Gm., bottles of 24 and 100. Dosage: Adults, 0.5 Gm. (1 tablet) daily, following an initial first day dose of 1 Gm. (2 tablets).

KYNEX Acetyl Pediatric Suspension, cherry-flavored, 250 mg. sulfamethoxypyridazine activity per teaspoonful (5 cc.). Bottles of 4 and 16 fl. oz. Recommended Dosage: Children under 80 lbs.: 1 teaspoonful (250 mg.) for each 20 lb. body weight, the first day, and ½ teaspoonful per 20 lb. per day thereafter. For children 80 lbs. and over: 4 teaspoonfuls (1.0 Gm.) initially and 2 teaspoonfuls daily thereafter. Give immediately after a meal.

KYNEX®

Sulfamethoxypyridazine Lederle

NEW—for acute G.U. infection AZO-KYNEX® Phenylazodiaminopyridine HCl—Sulfamethoxypyridazine Tablets, contains 125 mg. KYNEX in the shell with 150 mg. phenylazodiaminopyridine HCl in the core. Dosage: 2 tablets q.i.d. the first day; 1 tablet q.i.d. thereafter.

LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, New York

Lederle

CLINICAL REMISSION IN A "PROBLEM" ARTHRITIC

In rheumatoid arthritis with diabetes mellitus. A 54-year-old diabetic with a four-year history of arthritis was started on DECADRON, 0.75 mg./day, to control severe symptoms. After a year of therapy with 0.5 to 1.5 mg. daily doses of DECADRON, she has had no side effects and diabetes has not been exacerbated. She is in clinical remission.*

New convenient b.i.d. alternate dosage schedule: the degree and extent of relief provided by DECADRON allows for b.i.d. maintenance dosage in many patients with so-called "chronic" conditions. Acute manifestations should first be brought under control with a t.i.d. or q.i.d. schedule.

Supplied: As 0.75 mg. and 0.5 mg. scored, pentagon-shaped tablets in bottles of 100. Also available as Injection DECADRON Phosphate. Additional information on DECADRON is available to physicians on request. DECADRON is a trademark of Merck & Co., Inc.

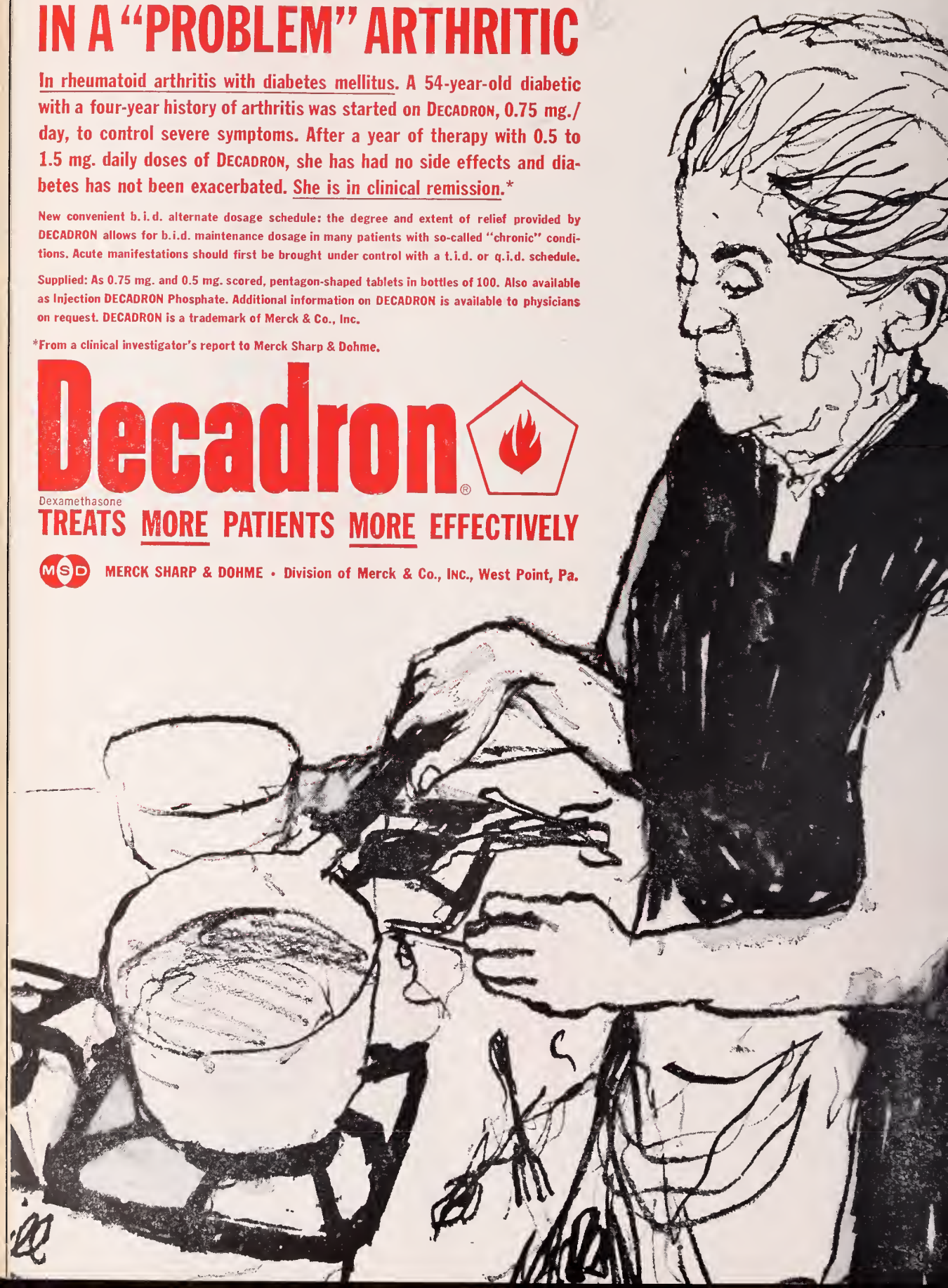
*From a clinical investigator's report to Merck Sharp & Dohme.

Decadron®

Dexamethasone

TREATS MORE PATIENTS MORE EFFECTIVELY

MSD MERCK SHARP & DOHME • Division of Merck & Co., INC., West Point, Pa.



NEW *For the multi-system disease HYPERTENSION*

SALUTENSIN™

Hydroflumethiazide • Reserpine • Protoveratrine A

An integrated multi-therapeutic antihypertensive, that combines in balanced proportions three clinically proven antihypertensives.

In each **SALUTENSIN** Tablet:

Saluron® (hydroflumethiazide)—a saluretic-antihypertensive ..... 50 mg.

Reserpine—a tranquilizing drug with peripheral vasorelaxant effects ..... 0.125 mg.

Protoveratrine A—a centrally mediated vasorelaxant ..... 0.2 mg.

Comprehensive information on dosage and precautions in official package circular or available on request.

BRISTOL LABORATORIES • Syracuse, New York

STEREO WEBCOR

$329.95

WEBCOR REGENT CORONET STEREO HI-FI TAPE RECORDER

- Will record and play back both stereo and monaural tapes
- Provides 2-channel and 4-channel stereo playback
- Dual-channel 16-watt amplifier
- Self-contained Stereo system with 2 Hi-Fi Speakers
- 2 directional microphones
- In ebony with silver trim

Model 2007

Available at all

DEPT. STORES AND BETTER MUSIC, RECORD, CAMERA AND APPLIANCE DEALERS

Write for catalog to Exclusive N. J. Wholesale Distributors

ALL-STATE DISTRIBUTORS,

INCORPORATED

457 CHANCELLOR AVENUE - WAverly 3-4900 - NEWARK, N. J.

NaClex®

benzthiazide

a new diuretic with an unsurpassed faculty for salt excretion

as salt goes, so goes edema

A basic principle of diuresis is that "increased urine volume and loss of body weight are proportional to and the osmotic consequences of loss of ions."[1]

Robins' new NaClex is a potent, oral, non-mercurial diuretic that helps reduce edema through the application of this fundamental principle. It limits the reabsorption of sodium and chloride in the renal proximal tubules (*with a relative sparing of potassium*). The body's homeostatic mechanism responds by increasing the excretion of excess extracellular water. Thus the NaClex-induced removal of salt leads to a reduction of edema.

a unique chemical structure

NaClex (benzthiazide) is a new molecule which provides a "pronounced increase in diuretic potency"[2] over its antecedent sulfonamide compound. Compared tablet for tablet with current oral diuretics, it is unsurpassed in diuretic potency.

twofold value

NaClex produces diuresis, weight loss, and symptomatic improvement in edema associated with various conditions. It also has antihypertensive properties and may be used alone in mild hypertension or with other antihypertensive drugs in severer cases.

For complete dosage schedules, precautions, or other information about NaClex, please consult basic literature, package insert, or your local Robins representative, or write to the A. H. Robins Co., Inc.

Supply: Yellow, scored 50 mg. tablets.

References: 1. Pitts, R. F., Am. J. Med., 24:745, 1958. 2. Ford, R. V., Cur. Therap. Res., 2:51, 1960.

A. H. ROBINS COMPANY, INC.
RICHMOND 20, VIRGINIA

What's she doing that's of medical interest?

She's drinking a glass of pure Florida orange juice. And that's important to her physician for several reasons.

How your patients obtain their vitamins or any of the other nutrients found in citrus fruits is of great medical interest — considering the fact there are so many wrong ways of doing it, so many substitutes and imitations for the real thing.

Actually, there's no better way for this young lady to obtain her vitamin C than by doing just what she is doing, for there's no better source than oranges and grapefruit ripened in the Florida sunshine. There's no substitute for the result of nature's own mysterious chemistry, flourishing in the warmth of this luxurious peninsula.

An obvious truth, you might say, but not so obvious to the parents of many teen-agers.

We know that a tall glass of orange juice is just about the best thing they can reach for when they raid the refrigerator. We also know that if you encourage this refreshing and healthful habit, you'll be helping patients to the finest between-meals drink there is.

Nothing has ever matched the quality of Florida citrus — watched over as it is by a State Commission that enforces the world's highest standards for quality in fresh, frozen, canned or cartoned citrus fruits and juices.

That's why the young lady's activities are of medical interest.

©Florida Citrus Commission, Lakeland, Florida

SAUNDERS BOOKS

New!—A Manual and Atlas for the General Surgeon

Marble—The Hand

This unusual book is aimed at the needs of the general practitioner, general surgeon and industrial physician—the men who see hand injuries first. Full page plates and explicit text give you quick instructions on treating every type of hand injury you are likely to see—from *lacerations* and *puncture wounds* to *fractures* and *crushing injuries.*

Extensive coverage is given to closed injuries of the hand and their management: *contusions, swellings, avulsion of tendons, burns, sprains, frostbite, fractures and dislocations.* Open injuries are then considered. Beautiful drawings illustrate *methods of tendon advancement; repair of lacerated nerve; skin-graft; repair of traumatic amputation of finger; etc.* Separate chapters cover: splinting; infections; and tumors of the hand.

By HENRY C. MARBLE, M.D., F.A.C.S., Consulting Surgeon to the Massachusetts General Hospital. 207 pages, 6½"x9¾", illustrated. $7.00. *Ready January!*

New!—Solid Information on Every Phase of Modern Hypnotic Practice

Meares—A System of Medical Hypnosis

Here is sound advice on how to apply hypnosis safely and effectively in your everyday practice. Dr. Meares gives step-by-step instructions for each method of induction: by direct stare; by suggestions for relaxation; by arm levitation; etc. He gives practical help on choosing the right method of induction for a particular case.

You'll find suggestions for clinical use of hypnosis in relief of pain and insomnia; as an aid to diagnosis; and as an anesthetic agent. The value of hypnosis in obstetrics and delivery is clearly discussed—with methods, problems and complications pointed up in rich detail. There are useful hints on applying hypnosis in the treatment of various gynecologic disorders, chronic illness, psychogenetic obesity, and alcoholism.

By AINSLIE MEARES, M.D., D.M.P., Melbourne, Australia. President, International Society for Clinical and Experimental Hypnosis. 484 pages, 6"x9¼". About $10.00. *New—Just Ready!*

New!—Sound Advice on Meeting Hundreds of Surgical Hazards

Artz & Hardy—Complications in Surgery & Their Management

With the aid of 69 authorities, the editors have compiled a complete text on the pitfalls of surgery—from preoperative preparation through post-operative convalescence. The authors cover general complications that may occur in almost any type of surgery, such as infections, wound dehiscence, shock, transfusion reactions, etc. Next, the management of special problems of severe pain, anesthetic complications, nutritional problems and emotional crises is clearly described. More than half of the book is devoted to the specific complications that arise in particular surgical operations.

Comprehensive chapters detail complications of: *antibiotic therapy—radiation therapy—pulmonary resection—splenectomy—appendectomy—pediatric surgery—hernia repair—surgery of the breast—common fractures—burns—etc.*

Edited by CURTIS P. ARTZ, M.D., F.A.C.S., Associate Professor of Surgery; and JAMES D. HARDY, M.D., F.A.C.S., Professor and Chairman of the Department of Surgery, University of Mississippi. With Contributions by 69 other Authorities. 1075 pages, 7"x10", with 271 illustrations. $23.00. *New!*

SJG-12-60

Order Today from **W. B. SAUNDERS COMPANY**
West Washington Square Philadelphia 5

Please send and charge my account:
☐ Marble—The Hand: A Manual & Atlas for the General Surgeon, $7.00. (Send when ready)
☐ Meares—A System of Medical Hypnosis, about $10.00.
☐ Artz & Hardy—Complications in Surgery & Their Management, $23.00.

Name_____

Address_____

PROVEN . . . MILLIONS USED . . . effectively

for Spastic Tension States

SED-TENS TY-MED*

RELAXES THE SPASTIC G. I. TRACT RELIEVES NAUSEA IN PREGNANCY

Provides superior anticholinergic-antitensive action through smooth, consistent and prolonged release of drugs over a 10 to 12 hour period.

The rate of release is independent of location in the gastrointestinal system—the same rate in ***ACID*** *or* ***ALKALINE*** *media.*

DOSAGE: One tablet morning and night.

Each Ty-Med* tablet contains:

Amobarbital	50 mg.
Homatropine Methylbromide	7.5 mg.

*LEMMON Brand of timed-release medication.

A clinical supply of SED-TENS Ty-Med tablets is available from . . .

LEMMON PHARMACAL CO.
Sellersville, Pa.

QUALITY PURITY SERVICE
LEMMON
PHARMACAL COMPANY

chronic leg ulcer?

"many patients who had ulcers from one to eight years obtained complete healing in six to ten weeks."[1]

CHLORESIUM® ointment

CHLORESIUM Ointment has long been recognized as a medication of choice for local treatment of chronic wounds and ulcerations.[1,2] This time-tested agent is noted for its ability to promote healthy granulation, encourage normal epithelization, relieve pain and inflammation, and deodorize malodorous lesions. Furthermore, a complete lack of irritating or sensitizing properties makes CHLORESIUM ideal for patient-use at home.

CHLORESIUM Ointment—0.5% water-soluble chlorophyll derivatives in a hydrophilic ointment base, in 1-oz. and 4-oz. tubes.

CHLORESIUM Solution—0.2% water-soluble chlorophyll derivatives in isotonic saline solution, in 2-oz. and 8-oz. bottles.

(1) Boehme, E. J.: Lahey Clin. Bull. **4**:242, 1946. (2) Diamond, O. K.: New York J. Med. **59**:1792, 1959.

Samples and literature available on request

Rystan Mount Vernon, N.Y.

34760

new clinical study[1] cites beneficial results in over 90% of cases in dry, itchy, scaly skin with Sardo®

Use of **SARDO** in 118 dermatological patients to relieve dry, itchy, scaly, fissured skin achieved these excellent results:

CASES	AFTER SARDO*		
	Excellent	Good	Poor
49 Senile skin	32	13	4
26 Dry Skin in younger patients (diabetes, etc.)	14	11	1
20 Atopic dermatitis	8	10	2
13 Actinic changes	9	4	–
10 Ichthyosis	3	4	3
Skin Conditions	Benefited	No Benefit	
20 Nummular dermatitis	19	1	
10 Neurodermatitis	10	–	

SARDO acts[1,2] to (A) lubricate and soften skin, (B) replenish natural emollient oil, (C) prevent excessive evaporation of essential moisture.

SARDO releases millions of microfine water-miscible globules to provide a soothing suspension which enhances the efficacy of your other therapy.

SARDO is pleasant, convenient, easy to use; non-sticky, non-sensitizing. Bottles of 4, 8 and 16 oz.

1. Weissberg, G.: Clin. Med., June 1960.

2. Spoor, H. J.: N. Y. St. J. Med., Oct. 15, 1958.

*patent pending
T.M. ©1960

for **SAMPLES** and complete reprint of Weissberg paper, please write . . .

Sardeau, Inc. 75 East 55th Street, New York 22, N. Y.

"Well, I'll send the culture to the lab, and we should hear from Bacteriology in a day or two. Now, how shall we treat her cystitis while we're waiting?"

"The chief usually orders AZOTREX. *The azo dye is an excellent urinary analgesic and the sulfamethizole and tetracycline are likely to take care of most of the bugs you find in the urinary tract. If necessary, you can switch to something else after you get the lab findings. But it probably won't be necessary."*

Azotrex®

Each AZOTREX capsule contains: TETREX® (tetracycline phosphate complex) equivalent to tetracycline HCl activity...125 mg.; sulfamethizole . . . 250 mg.; phenylazo-diamino-pyridine HCl . . . 50 mg. Supply: Bottles of 24 and 100.

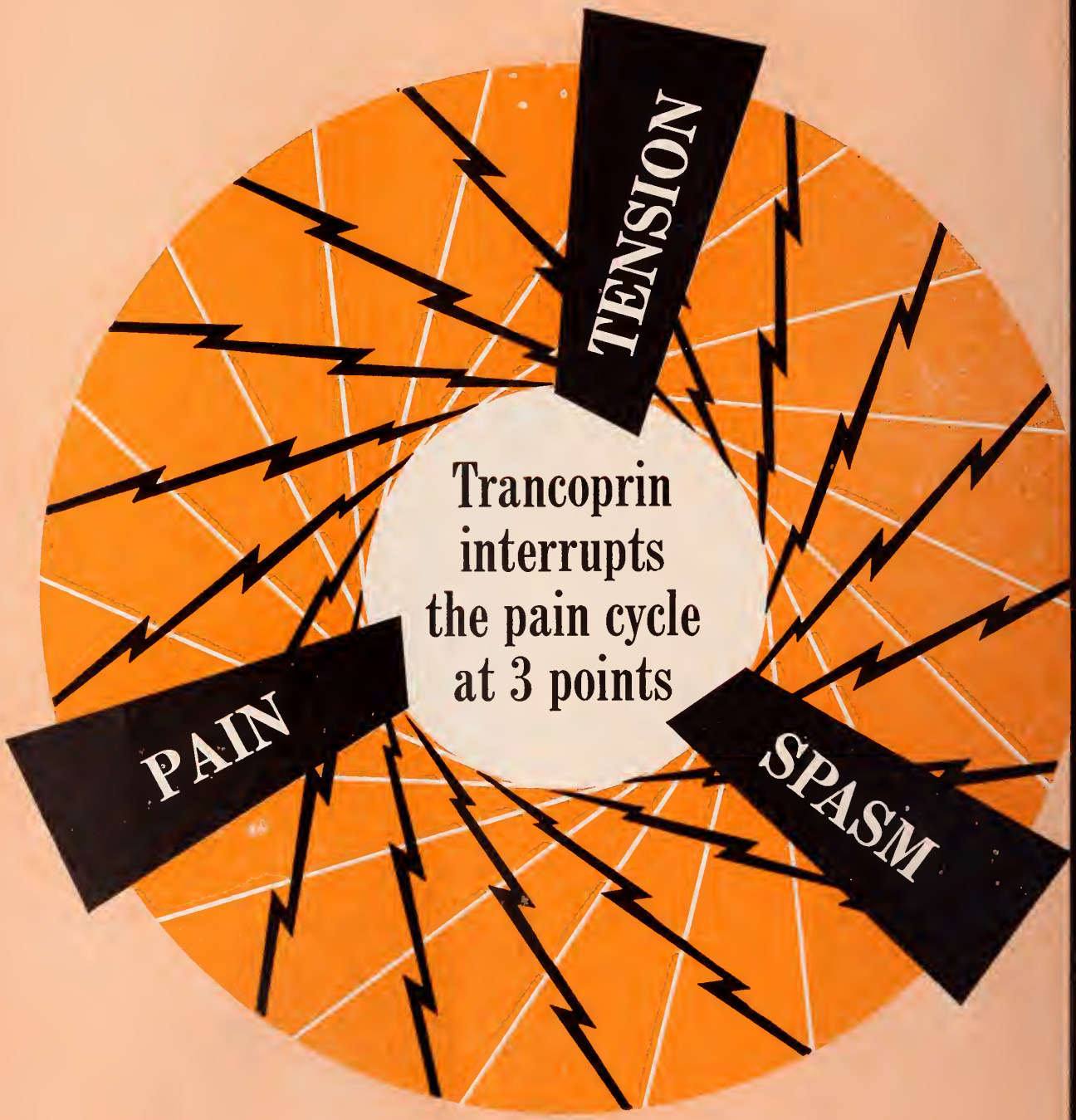
BRISTOL™
BRISTOL LABORATORIES
Div. of Bristol-Myers Co.
SYRACUSE, NEW YORK

announcing...

Trancoprin

acetylsalicylic acid (300 mg.) and chlormezanone (50 mg.)

Tablets



a broad spectrum non-narcotic analgesic

Trancoprin, a new analgesic, not only raises the pain perception threshold but, through its chlormezanone component, also relaxes skeletal muscle spasm[1-6] and quiets the psyche.[2,3-5,7]

The effectiveness of Trancoprin has been demonstrated clinically[8] in a number of patients with a wide variety of painful disorders ranging from headache, dysmenorrhea and lumbago to arthritis and sciatica. In a series of 862 patients,[8] Trancoprin brought excellent or good relief of pain to 88 per cent of the group. In another series,[9] Trancoprin was administered in an industrial dispensary to 61 patients with headache, bursitis, neuritis or arthritis. The excellent results obtained prompted the prediction that Trancoprin "... will prove a valuable and safe drug for the industrial physician."[9]

Exceptionally Safe

No serious side effects have been encountered with Trancoprin. Of 923 patients treated with Trancoprin, only 22 (2.4 per cent) experienced any side effects.[8,9] In every instance, these reactions, which included temporary gastric distress, weakness or sedation, were mild and easily reversed.

Indications

Trancoprin is recommended for more comprehensive control of the pain complex (pain → tension → spasm) in those disorders in which tension and spasm are complicating factors, such as: headaches, including tension headaches / premenstrual tension and dysmenorrhea / low back pain, sciatica, lumbago / musculoskeletal pain associated with strains or sprains, myositis, fibrositis, bursitis, trauma, disc syndrome and myalgia / arthritis (rheumatoid or hypertrophic) / torticollis / neuralgia.

Dosage

The usual adult dosage is 2 Trancoprin tablets three or four times daily. The dosage for children from 5 to 12 years of age is 1 tablet three or four times daily. Trancoprin is so well tolerated that it may be taken on an empty stomach for quickest effect. The relief of symptoms is apparent in from fifteen to thirty minutes after administration and may last up to six hours or longer.

How Supplied

Each Trancoprin tablet contains 300 mg. (5 grains) of acetylsalicylic acid and 50 mg. of chlormezanone [Trancopal® brand]. Bottles of 100 and 1000.

Trancoprin Tablets / non-narcotic analgesic

References: 1. DeNyse, D. L.: *M. Times* 87:1512, Nov., 1959. 2. Ganz, S. E.: *J. Indiana M. A.* 52:1134, July, 1959. 3. Gruenberg, Friedrich: *Current Therap. Res.* 2:1, Jan., 1960. 4. Kearney, R. D.: *Current Therap. Res.* 2:127, April, 1960. 5. Lichtman, A. L.: *Kentucky Acad. Gen. Pract. J.* 4:28, Oct., 1958. 6. Mullin, W. G., and Epifano, Leonard: *Am. Pract. & Digest Treat.* 10:1743, Oct., 1959. 7. Shanaphy, J. F.: *Current Therap. Res.* 1:59, Oct., 1959. 8. Collective Study, Department of Medical Research, Winthrop Laboratories. 9. Hergesheimer, L. H.: An evaluation of a muscle relaxant (Trancopal) alone and with aspirin (Trancoprin) in an industrial medical practice, to be submitted.

Winthrop LABORATORIES, New York 18, N. Y.

CONSISTENTLY GOOD CLINICAL RESULTS IN TRICHOMONAL AND MONILIAL VAGINITIS

TRICOFURON IMPROVED (Suppositories and Powder) cured 143 of 161 patients with vaginitis due to Trichomonas vaginalis, Candida (Monilia) albicans, or both. "Almost immediate symptomatic improvement was noted with the first insufflation."

Criteria for cure: freedom from infecting organisms as well as symptoms on repeated examinations during a three-month follow-up. This cure rate of 88.8% is "surprisingly similar" to results reported by earlier investigators.

Coolidge, C. W.; Glisson, C. S., and Smith, A. S.: J.M.A. Georgia 48:167, 1959.

TRICOFURON®

IMPROVED

2-step treatment brings swift relief, eradicates stubborn trichomonads, Candida (Monilia) albicans, Hemophilus vaginalis

1. POWDER for weekly insufflation in your office. MICOFUR®, brand of nifuroxime, 0.5% and FUROXONE®, brand of furazolidone, 0.1% in an acidic water-dispersible base.

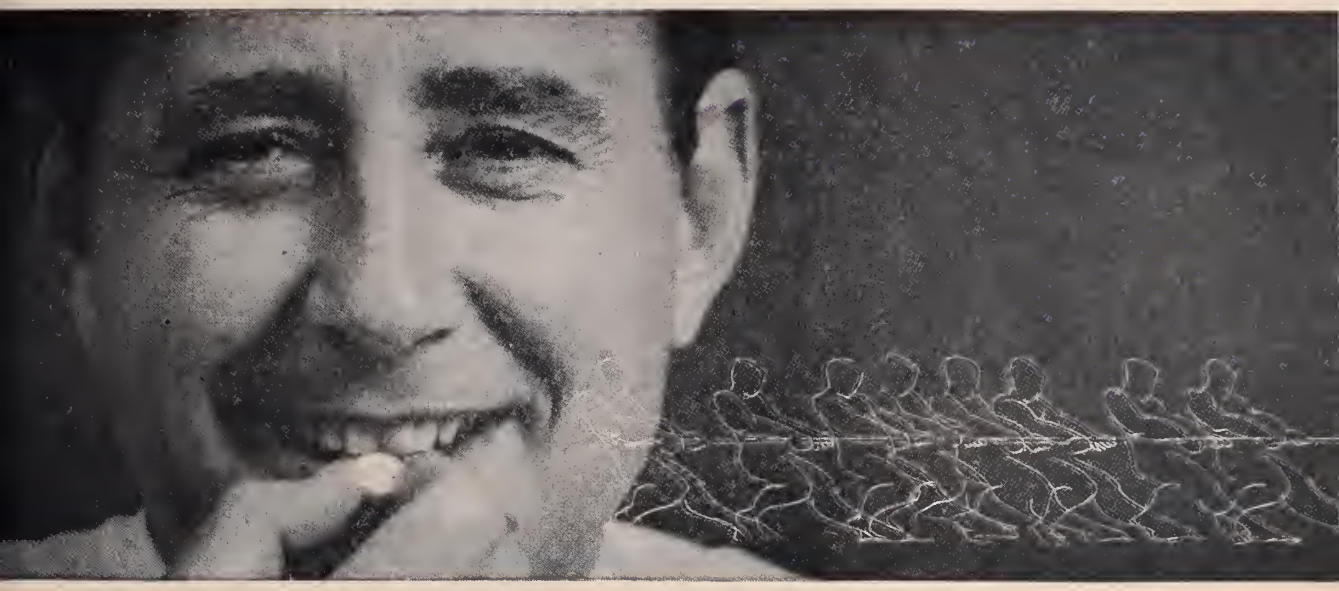
2. SUPPOSITORIES for continued home use —1st week one suppository in the morning and one on retiring. After 1st week, one suppository at night may suffice.

Continue use of suppositories during menses. Treatment should be continued throughout a complete menstrual cycle and for several days thereafter. MICOFUR 0.375% and FUROXONE 0.25% in a water-miscible base.

Rx new box of 24 suppositories with applicator for more practical and economical therapy. Also available: box of 12 suppositories with applicator.

NITROFURANS—a *unique* class of antimicrobials
EATON LABORATORIES, NORWICH, NEW YORK

in antacid therapy...
patient cooperation is half the battle



Are you chancing unsatisfactory results because the patient doesn't like the taste of the antacid you have prescribed? Assure patient cooperation. Prescribe the antacid which assures patient acceptance through its excellent palatability.

'Palatable Margel'

unsurpassed in performance
unequalled in palatability

antacid suspension/tablets

MARGEL is a highly palatable formulation of four antacids: selected aluminum hydroxides, magnesium hydroxide, magnesium trisilicate and calcium carbonate. Balanced to be non-constipating; formulated to be non-chalky. Write for a sample and see for yourself.

Supplied: Margel Suspension — bottles of 12 fluid ounces. Margel Tablets — boxes of 96.
Dosage: SUSPENSION: 1 tablespoonful 20 minutes after meals and on retiring. May be taken with milk if desired. TABLETS: 2 or more tablets 20 minutes after meals and on retiring. May be chewed or allowed to dissolve slowly in the mouth.

MRT *M.R. Thompson, Inc.* CRANFORD, N. J.

when she's not like herself anymore

Metalex® basic in the care of the aging

when body tone, mental and sensory faculties begin to fade—*she's irritable, confused, forgetful, apathetic*

when voices begin to fade—*in loss of auditory acuity, in tinnitus*

when vision begins to dim—*in loss of visual acuity, in loss of peripheral vision*

℞ Metalex® *cerebral stimulant / vasodilator*

The stimulant—pentylenetetrazol—facilitates cerebral and reflex nerve activity.

The vasodilator—nicotinic acid—augments blood and oxygen supply to vital areas—

Thus, METALEX increases body tone and aids mental and sensory faculties.

Composition: Each teaspoonful (5 ml.) of the Elixir and each Tablet contains: Pentylenetetrazol 100 mg., Nicotinic Acid 50 mg.

Dosage: One or two teaspoonfuls of the Elixir or one or two Tablets four times a day—one-half hour before meals and before bedtime.

Available: Elixir: Pint and Gallon bottles. Tablets: Bottles of 100 and 1000.

References: 1. Goodman, L. S. and Gilman, A.: The Pharmacological Basis of Therapeutics, 2nd Ed., New York, Macmillan Company, 1955. 2. O'Reilly, P. O., Demay, M. and Kotlowski, K.: Cholesteremia and Nicotinic Acid. A.M.A. Arch. Int. Med. 100:797-801 (Nov.) 1957.

STORCK Pharmaceuticals, Inc.,
2326 Hampton Blvd., St. Louis 10, Mo.

in rheumatic disorders

whenever aspirin proves inadequate

Sterazolidin®

brand of prednisone-phenylbutazone

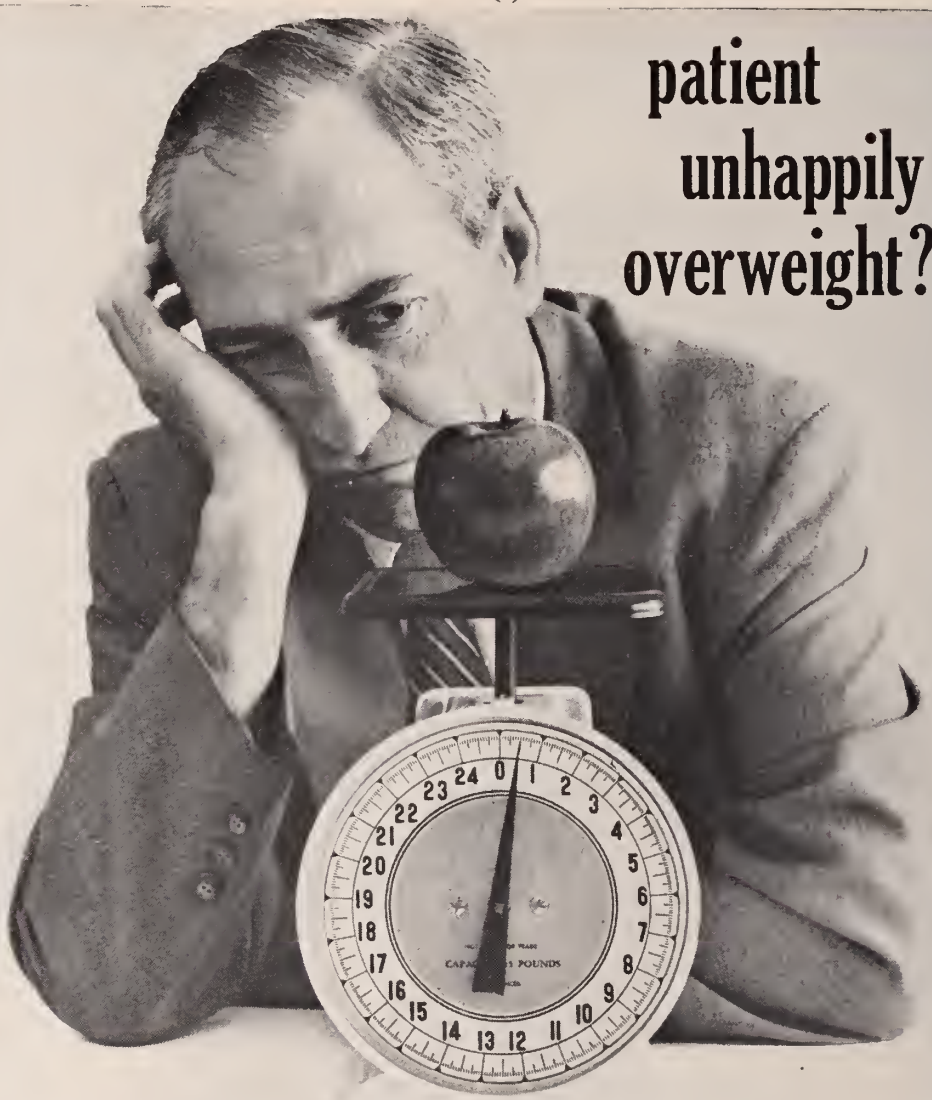
Even in the more transient rheumatic disorders, an anti-inflammatory effect more potent than that provided by aspirin is often desirable to hasten recovery and get the patient back to work.
By combining the anti-inflammatory action of prednisone and phenylbutazone, Sterazolidin brings about exceptionally rapid resolution of inflammation with relief of symptoms and restoration of function.
Since Sterazolidin is effective in low dosage, the possibility of significant hypercortisonism, even in long-term therapy, is substantially reduced.

Availability: Each Sterazolidin® capsule contains prednisone 1.25 mg.; Butazolidin®, brand of phenylbutazone, 50 mg.; dried aluminum hydroxide gel 100 mg.; magnesium trisilicate 150 mg.; and homatropine methylbromide 1.25 mg. Bottles of 100 capsules.

Geigy, Ardsley, New York

Geigy

165-60



minimize care and eliminate despair with "METHEDRINE"®

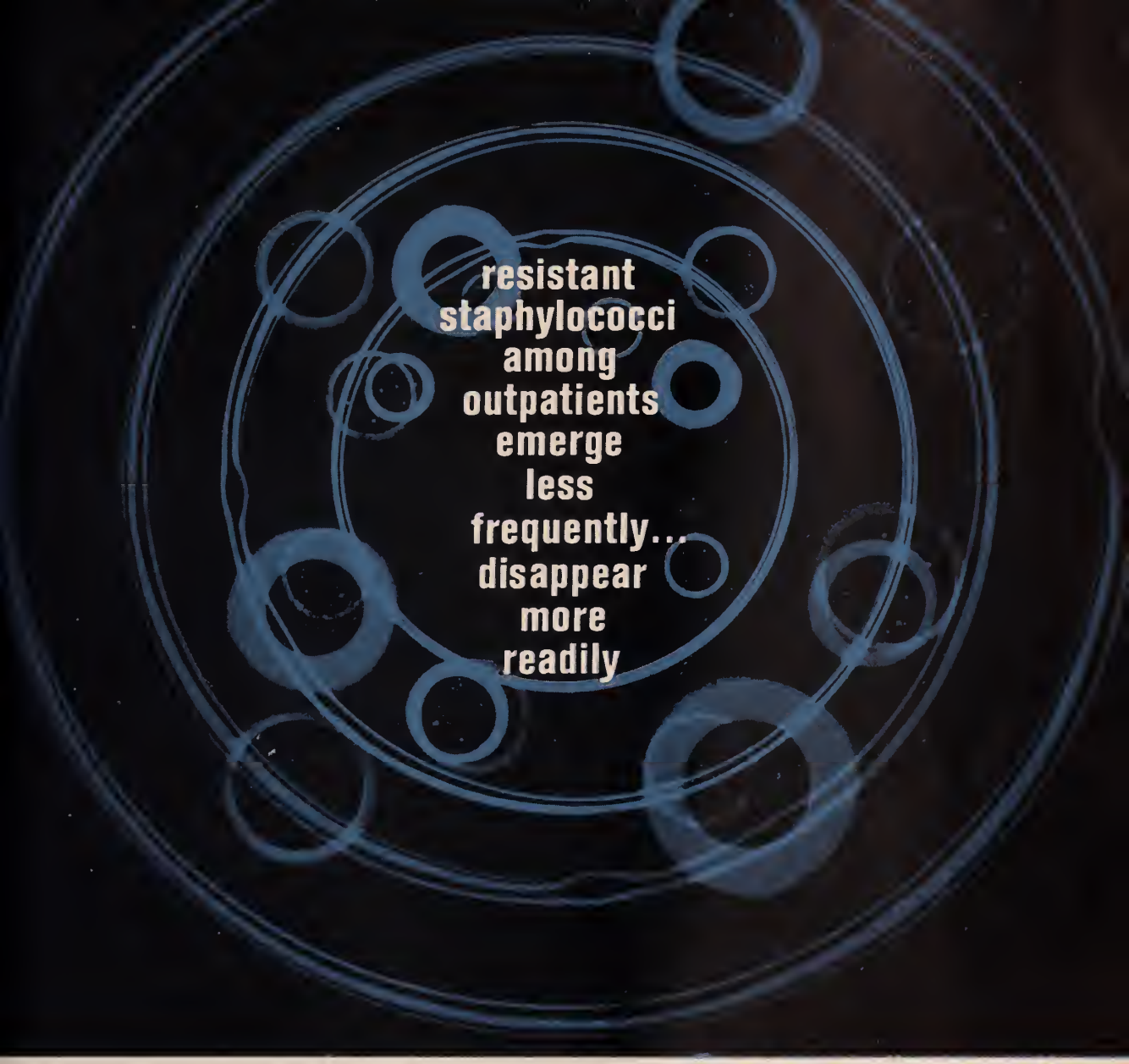
brand Methamphetamine Hydrochloride

Controls food craving, keeps the reducer happy—In obesity, "our drug of choice has been methedrine . . . because it produces the same central effect with about one-half the dose required with plain amphetamine, because the effect is more prolonged, and because undesirable peripheral effects are significantly minimized or entirely absent."[1] Literature available on request.

Supplied: Tablets 5 mg., scored. Bottles of 100 and 1000.

[1] Douglas, H. S.: West. J. Surg. 59:238 (May) 1951.

BURROUGHS WELLCOME & CO. (U. S. A.) INC., Tuckahoe, New York



CHLOROMYCETIN®

chloramphenicol, Parke-Davis

IN VITRO SENSITIVITY OF COAGULASE-POSITIVE STAPHYLOCOCCI TO CHLOROMYCETIN FROM 1955 TO 1959*

These sensitivity tests were done by the disc method on 310 strains of coagulase-positive staphylococci. Strains were isolated from patients seen in the emergency room. It should be noted that among inpatients, resistant strains were considerably more prevalent.

*Adapted from Bauer, A. W.; Perry, D. M., & Kirby, W. M. M.: *J.A.M.A.* 173:475, 1960.

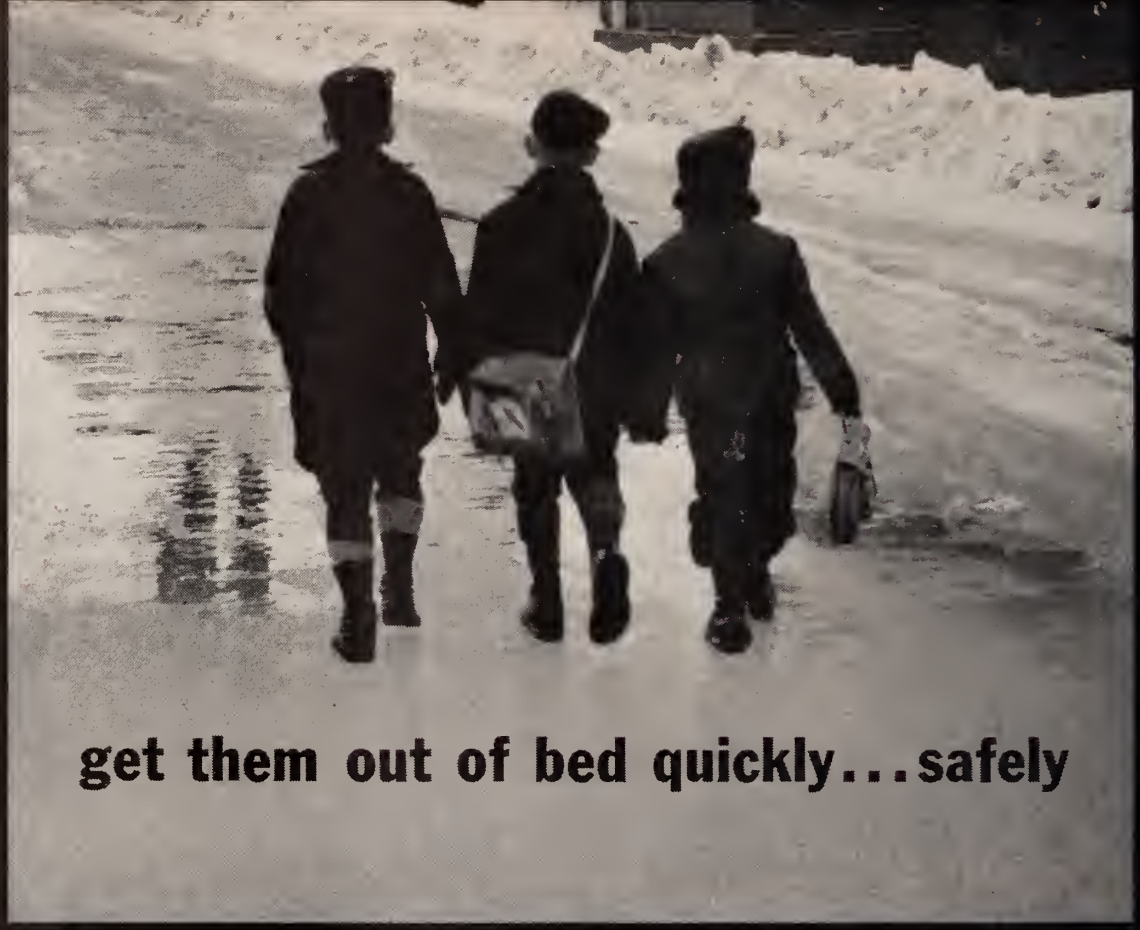
10360

CHLOROMYCETIN (chloramphenicol, Parke-Davis) is available in various forms, including Kapseals® of 250 mg., in bottles of 16 and 100.

CHLOROMYCETIN is a potent therapeutic agent and, because certain blood dyscrasias have been associated with its administration, it should not be used indiscriminately or for minor infections. Furthermore, as with certain other drugs, adequate blood studies should be made when the patient requires prolonged or intermittent therapy.

PARKE-DAVIS

PARKE, DAVIS & COMPANY · DETROIT 32 MICHIGAN



with **tri-sulfanyl**

sulfonamide therapy at its best

rapid, maximum recovery assured... because of rapid, prolonged high blood and tissue levels of triple sulfa mixtures.

worry-free therapy... safer, because of high urine solubility that makes risk of crystalluria virtually negligible. As specific as antibiotics in many infections, but avoids certain of their complications. Danger of moniliasis, gastric upsets, bacterial resistance, sensitivity, blood dyscrasia, etc. reduced to a minimum.

the candy-like flavor of Tri-Sulfanyl Syrup appeals to infants, children, women, all patients.

economical... costs far less than broad spectrum antibiotics . . . more effective than single sulfas.

Each 5 cc. of Tri-Sulfanyl syrup (approx. one teaspoonful) or each tablet contains 7½ grains of sulfa compound:

Sulfadiazine	0.162 Gm.
Sulfamerazine	0.162 Gm.
Sulfathiazole	0.162 Gm.
Sodium Citrate*	0.375 Gm.

*not contained in Tri-Sulfanyl Tablets.

Tri-Sulfanyl Syrup: 4 oz., 16 oz., and gallon
Tri-Sulfanyl Tablets: 100 and 500

SAMPLES and new literature on request.

arlington-funk laboratories
division of U. S. Vitamin Corporation
250 East 43rd St., New York 17, N.Y.

In over five years

Proven

in more than 750 published clinical studies

Effective

for relief of anxiety and tension

Outstandingly Safe

1 simple dosage schedule produces rapid, reliable tranquilization without unpredictable excitation

2 no cumulative effects, thus no need for difficult dosage readjustments

3 does not produce ataxia, change in appetite or libido

4 does not produce depression, Parkinson-like symptoms, jaundice or agranulocytosis

5 does not impair mental efficiency or normal behavior

Miltown®

meprobamate (Wallace)

Usual dosage: One or two 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets.
Also as MEPROTABS* — 400 mg. *unmarked*, coated tablets; and as MEPROSPAN® — 400 mg. and 200 mg. *continuous release* capsules.

WALLACE LABORATORIES / *Cranbury, N. J.*

CM-2537

*TRADE-MARK

# of clinical use...

...for the tense and nervous patient

Despite the introduction in recent years of "new and different" tranquilizers, Miltown continues, quietly and steadfastly, to gain in acceptance. Meprobamate (Miltown) is prescribed by the medical profession more than any other tranquilizer in the world.

The reasons are not hard to find. Miltown is a ***known*** drug. Its few side effects have been fully reported. ***There are no surprises in store for either the patient or the physician.***

NEW analgesic

Kills pain

stops tension

For neuralgias, dysmenorrhea, upper respiratory distress, postsurgical conditions... new compound kills pain, stops tension, reduces fever—gives more complete relief than other analgesics.

Soma Compound is an entirely new, totally different analgesic combination that contains three drugs. First, Soma: a new type of analgesic that has proved to be highly effective in relieving both pain and tension.* Second, phenacetin: a "standard" analgesic and antipyretic. Third, caffeine: a safe, mild stimulant for elevation of mood. As a result, the patient gets more complete relief than he does with other analgesics.

Soma Compound is nonnarcotic and nonaddicting. It reduces pain perception without impairing the natural defense reflexes.*

NEW NONNARCOTIC ANALGESIC

soma® Compound

Composition: Soma (carisoprodol), 200 mg. phenacetin, 160 mg.; caffeine, 32 mg.
Dosage: 1 or 2 tablets q.i.d.
Supplied: Bottles of 50 apricot-colored, scored tablets.

NEW FOR MORE SEVERE PAIN

soma® Compound + codeine

BOOSTS THE EFFECTIVENESS OF CODEINE: Soma Compound boosts the effectiveness of codeine. Therefore, only ¼ grain of codeine phosphate is supplied to relieve the more severe pain that usually requires ½ grain.

Composition: Same as Soma Compound plus ¼ grain codeine phosphate.
Dosage: 1 or 2 tablets q.i.d.
Supplied: Bottles of 50 white, lozenge-shaped tablets; subject to Federal Narcotics Regulations.

*References available on reques.

WALLACE LABORATORIES • Cranbury, N. J.

Recognizing that the exchange of ideas is fundamental to medical progress, Lederle continues its Symposium program with the 10th year of scheduled meetings. Through these Symposia, sponsored by medical organizations with our cooperation, over 50,000 physicians have had the opportunity to hear and question authorities on important advances in clinical medicine and surgery. You have a standing invitation to attend any of these Symposia with your wife, for whom a special program is planned.

ANOTHER YEAR OF SYMPOSIA . . .

PORTLAND, OREGON
Wednesday, January 11, 1961
The Sheraton-Portland Hotel

MONTGOMERY, ALABAMA
Friday, January 13, 1961
The Whitley Hotel

MINNEAPOLIS, MINNESOTA
Monday, January 16, 1961
The Hotel Leamington

LEMONT, ILLINOIS
Wednesday, January 18, 1961
The White Fence Farm

CINCINNATI, OHIO
Sunday, January 22, 1961
The Netherland Hilton Hotel

NEW DORP, STATEN IS., N. Y.
Wednesday, February 15, 1961
The Tavern-on-the-Green

CHARLESTON, SOUTH CAROLINA
Thursday, February 23, 1961
The Francis-Marion Hotel

ANCHORAGE, ALASKA
Saturday, February 25, 1961
The Westward Hotel

BAKERSFIELD, CALIFORNIA
Friday, March 3, 1961
The Bakersfield Hacienda

WILLIAMSBURG, VIRGINIA
Wednesday, March 8, 1961
The Williamsburg Lodge

ALBUQUERQUE, NEW MEXICO
Saturday, March 11, 1961
The Hilton Hotel

OMAHA, NEBRASKA
Thursday, March 16, 1961
The Sheraton-Fontenelle Hotel

PHOENIX, ARIZONA
Saturday, March 18, 1961
The Westward Ho Hotel

LOUISVILLE, KENTUCKY
Thursday, March 23, 1961
The Sheraton-Seelbach Hotel

BAY SHORE, LONG ISLAND, NEW YORK
Wednesday, April 12, 1961
The LaGrange Inn

BUTTE, MONTANA
Saturday, April 22, 1961
The Finlen Hotel

ITHACA, NEW YORK
Thursday, April 27, 1961
The Statler Club

ERIE, PENNSYLVANIA
Wednesday, May 3, 1961
The Hotel Lawrence

SACRAMENTO, CALIFORNIA
Wednesday, May 10, 1961
The El Dorado Hotel

LOS ANGELES, CALIFORNIA
Wednesday, June 7, 1961
The Statler Hotel

Lederle LEDERLE LABORATORIES, a Division of AMERICAN CYANAMID COMPANY, Pearl River, N. Y.

NEW PROTEIN TISSUE-BUILDING AGENT

ADROYD®

FOR SIGNIFICANT ANABOLIC GAINS IN: ASTHENIA (UNDERWEIGHT, ANOREXIA, LACK OF VIGOR); CONVALESCENCE FROM SURGERY OR SEVERE INFECTIONS; WASTING DISEASES; BURNS; FRACTURES; OSTEOPOROSIS; AND IN OTHER CATABOLIC STATES

■ PROMOTES AND MAINTAINS POSITIVE NITROGEN BALANCE ■ HELPS RESTORE APPETITE, STRENGTH, AND VIGOR ■ BUILDS FIRM, LEAN MUSCULAR TISSUE ■ FAVORABLY INFLUENCES CALCIUM AND PHOSPHORUS METABOLISM ■ PROMOTES A SENSE OF WELL-BEING

ADROYD PROVIDES HIGH ANABOLIC ACTIVITY—The tissue-building potential of ADROYD exceeds its androgenic action to the extent that masculinizing effects have not been a problem in clinical use.* Other advantages of ADROYD are: Neither estrogenic nor progestational. No significant fluid retention. Apparent freedom from nausea, vomiting, and other gastrointestinal disturbances. Effective by the oral route.

See medical brochure, available to physicians, for details of administration and dosage.

Supplied: 10-mg. scored tablets, bottles of 30. 48760

*Reports to Department of Clinical Investigation, Parke, Davis & Company, 1958 and 1959.

PARKE-DAVIS

PARKE, DAVIS & COMPANY · DETROIT 32, MICHIGAN

ALL OVER AMERICA!

KENT with the MICRONITE FILTER IS SMOKED BY MORE SCIENTISTS and EDUCATORS

than any other cigarette!*

KING-SIZE, REGULAR-SIZE OR CRUSH-PROOF BOX

THIS does not constitute a professional endorsement of Kent. But these men, like millions of other Kent smokers, smoke for pleasure, and choose their cigarette accordingly.

The rich pleasure of smoking Kent comes from the flavor of the world's finest natural tobaccos, and the free and easy draw of Kent's famous Micronite Filter.

If you would like the booklet, "The Story of Kent", for your own use, write to: P. Lorillard Company—Research Department, 200 East 42nd Street, New York 17, New York.

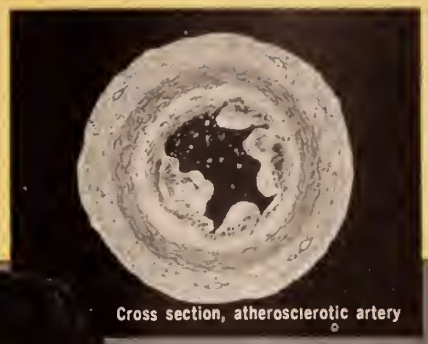
For good smoking taste, it makes good sense to smoke KENT

* Results of a continuing study of cigarette preferences, conducted by O'Brien-Sherwood Associates, N.Y., N.Y.

A PRODUCT OF P. LORILLARD COMPANY · FIRST WITH THE FINEST CIGARETTES · THROUGH LORILLARD RESEARCH

© 1960, P. LORILLARD CO.

outstanding nutritional research achievement


Cross section, atherosclerotic artery

to aid in the dietary control of serum cholesterol

MAZOLA®

MARGARINE
scientifically formulated with pure liquid non-hydrogenated MAZOLA Corn Oil.

MAZOLA Margarine is an economical tablespread and serves as a solid shortening, rich in linoleic acid and low in the more saturated fatty acids — making it an ideal dietary adjunct in the management of serum cholesterol. It contains 2 to 3 times as much linoleic acid as any other margarine in the grocery store, and 5 to 8 times as much as butter. It contains no dairy or animal fats, no coconut oil, and no cholesterol.

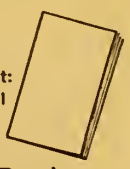
MAZOLA Margarine is indistinguishable from other quality margarines as to taste, aroma and handling characteristics. Thus, it can be part of the regular diet for the whole family, including the hypercholesterolemic patient. The major ingredient in MAZOLA Margarine — liquid MAZOLA Corn Oil—is NOT hydrogenated, thereby preserving its rich content of linoleates.

Two ounces or 56.8 Gm. (4 tablespoons) of MAZOLA Margarine supply:

Linoleic acid	12 Gm.
Oleic acid	23 Gm.
Saturated fatty acids	8 Gm.
Plant sterols (sitosterols)	215 mg.
Natural tocopherols	30 mg.
Vitamin A	1870 USP units
Vitamin D	250 USP units
Calories	415

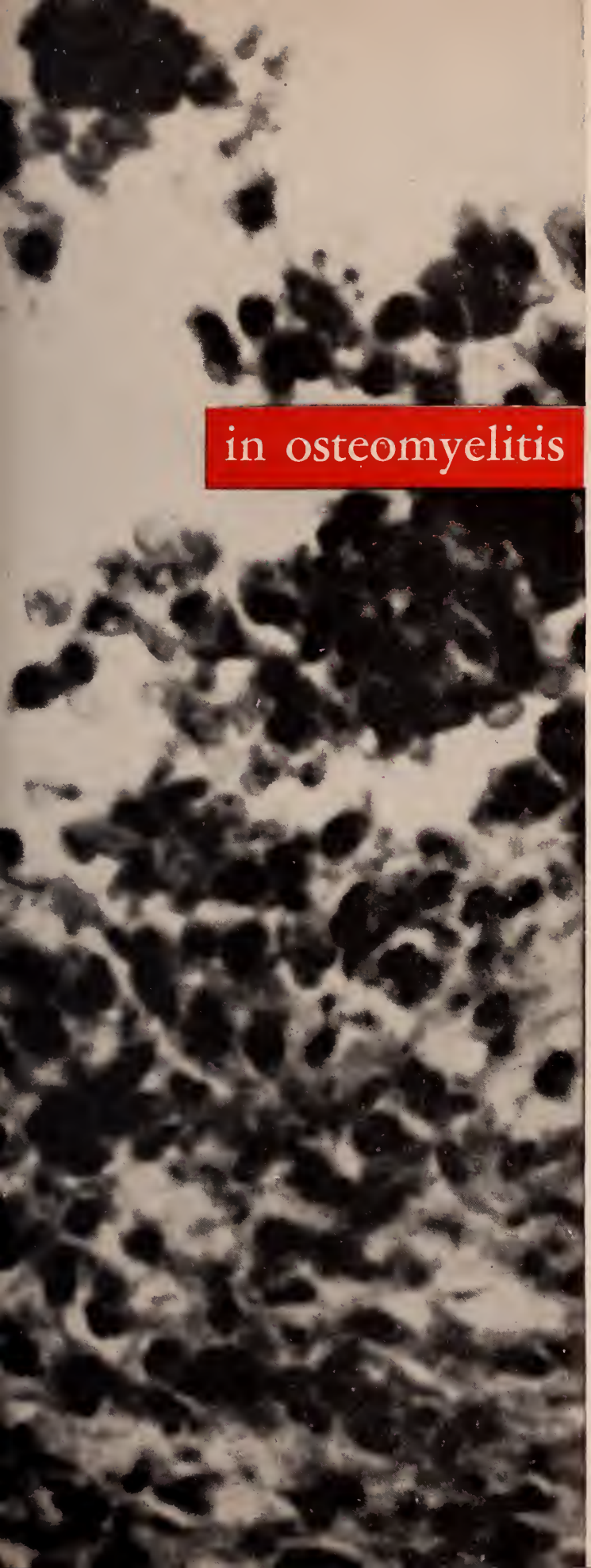
Available in the refrigerator sections of grocery stores in the same general price range as other premium quality margarines, in 1-lb. packages (four ¼ lb. sticks).

Send for free booklet:
"Recent Advances in the Dietary Control of Hypercholesterolemia."



BEST FOODS • Division of Corn Products Co., NEW YORK 22, N. Y.

Bone section: erosion and purulent exudate



Therapeutic confidence

Panalba is effective against more than 30 commonly encountered pathogens including ubiquitous staphylococci. Right from the start, prescribing it gives you a high degree of assurance of obtaining the desired anti-infective action in this as in a wide variety of bacterial diseases.

Supplied: Capsules, each containing Panmycin* Phosphate (tetracycline phosphate complex), equivalent to 250 mg. tetracycline hydrochloride, and 125 mg. Albamycin,* as novobiocin sodium, in bottles of 16 and 100.

*Trademark, Reg. U. S. Pat. Off.

The Upjohn Com
Kalamazoo, Mich

Upjohn

Panalba*

your broad-spectrum antibiotic of *first* resort

A special formulation for those troublesome cases of acute nonspecific diarrhea

DONNAGEL®-PG

Donnagel® with paregoric equivalent

Provides greater assurance of more comprehensive relief in acute self-limiting diarrheas through the time-tested effectiveness of two outstanding antidiarrheals—DONNAGEL and a paregoric equivalent. *Tastes good, too!*

Each 30 cc. (1 fl. oz.) of DONNAGEL-PG contains:

Powdered opium U.S.P. (equivalent to paregoric 6 ml.)	24.0 mg.
Kaolin	6.0 Gm.
Pectin	142.8 mg.
Natural belladonna alkaloids	
hyoscyamine sulfate	0.1037 mg.
atropine sulfate	0.0194 mg.
hyoscine hydrobromide	0.0065 mg.
Phenobarbital (¼ gr.)	16.2 mg.

SUPPLIED: Pleasant-tasting banana flavored suspension in bottles of 6 fl. oz.

Also available:

DONNAGEL® with NEOMYCIN — for control of bacterial diarrheas.

DONNAGEL® — the basic formula — when paregoric or an antibiotic is not required.

A. H. ROBINS CO., INC. Robins
RICHMOND 20, VIRGINIA

MICROBIOLOGICAL AND PHARMACOLOGICAL PROPERTIES

In vitro studies show that STAPHCILLIN is a bactericidal penicillin with activity against staphylococci resistant to penicillin G. Strains of staphylococci so far tested have been sensitive to STAPHCILLIN *in vitro* at concentrations of 1-6 mcg. per ml. These levels are readily attained in the blood and tissues by administration of STAPHCILLIN at the recommended dosage. This unique attribute is probably due to the fact that STAPHCILLIN is stable in the presence of staphylococcal penicillinase. STAPHCILLIN also resists degradation by *B. cereus* penicillinase. The antomicrobial spectrum of STAPHCILLIN with regard to other microorganisms is qualitatively similar to that of penicillin G; but considerably higher concentrations of STAPHCILLIN are required for bactericidal activity than is the case with penicillin G.

STAPHCILLIN is rapidly absorbed after intramuscular injection. Peak blood levels (6-10 mcg./ml. on the average after a 1.0 Gm. dose) are attained within 1 hour; and then progressively decline to less than 1 mcg. over a 4 to 6 hour period. It is poorly absorbed from the gastrointestinal tract. STAPHCILLIN is rapidly excreted by the kidney.

As shown by animal studies, STAPHCILLIN is readily distributed in body tissues after intramuscular injection. Of the tissues studied, highest concentrations are reached in the kidney, liver, heart and lung in that order; the spleen and muscles show lower concentrations of the antibiotic. STAPHCILLIN diffuses into human pleural and prostatic fluids, but its diffusion into the spinal fluid has not yet been completely studied. However, one patient with meningitis showed a significant concentration in his spinal fluid while on STAPHCILLIN therapy.

Toxicity studies with STAPHCILLIN and penicillin G in animals show that they have approximately the same low order of toxicity.

Certain staphylococci can be made resistant to STAPHCILLIN in the laboratory, but this resistance is not related to their penicillinase production. During the clinical trials, no STAPHCILLIN-resistant strains of staphylococci were observed or developed; the possibility of the emergence of such strains in the clinical setting awaits further observation.

PRECAUTIONS

During the clinical trials, several mild skin reactions, e.g., itching, papular eruption and erythema were observed both during and after discontinuance of STAPHCILLIN therapy. Patients with histories of hay fever, asthma, urticaria and previous sensitivity to penicillin are more likely to react adversely to the penicillins. It is important that the possibility of penicillin anaphylaxis be kept in mind. Epinephrine and the usual adjuvants (antihistamines, corticosteroids) should be available for emergency treatment. Because of the resistance of STAPHCILLIN to destruction by penicillinase, parenteral *B. cereus* penicillinase may not be effective for the treatment of allergic reactions. Information with regard to cross-allergenicity between penicillin G, penicillin V, phenethicillin (Syncillin) and STAPHCILLIN is not available at present. If superinfection due to Gram-negative organisms or fungi occurs during STAPHCILLIN therapy, appropriate measures should be taken.

SUPPLY

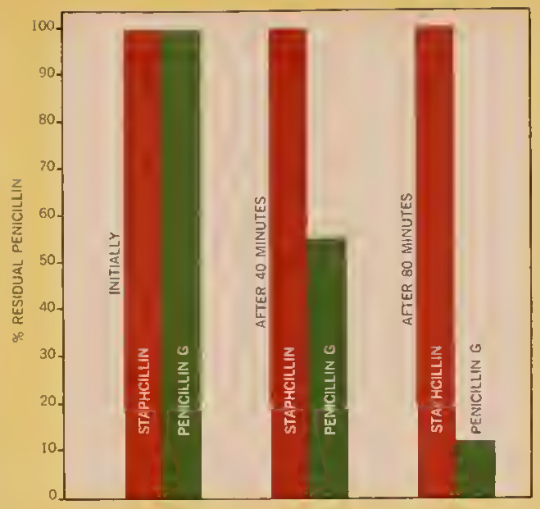
List 79502 — 1.0 Gm. dry filled vial.

BRISTOL LABORATORIES · SYRACUSE, NEW YORK
Division of Bristol-Myers Company

CUT HERE FOR FILING

UNIQUE SYNTHETIC "STAPH-CIDAL" PENICILLIN

CUT HERE FOR FILING



In the presence of staphylococcal penicillinase, STAPHCILLIN remained active and retained its antibacterial action. By contrast, penicillin G was rapidly destroyed in the same period of time. *(After Gourevitch et al., to be published)*

Specifically for "resistant" staph...

Staphcillin™

sodium dimethoxyphenyl penicillin
FOR INJECTION

The failure of staphylococcal infections to respond to penicillin therapy is attributed to the penicillin-destroying enzyme, penicillinase, produced by the invading staphylococcus.

Unlike other penicillins:

1 STAPHCILLIN is effective because it retains its antibacterial activity despite the presence of staphylococcal penicillinase.

2 The clinical effectiveness of STAPHCILLIN has been confirmed by dramatic results in a wide variety of infections due to "resistant" staphylococci, many of which were serious and life-threatening.

Like other penicillins:

STAPHCILLIN has no significant systemic toxicity. It is well tolerated locally, and pain or irritation at the injection site is comparable to that following the injection of penicillin G. *In occasional cases, typical penicillin reactions may be experienced.*

PROFESSIONAL INFORMATION SERVICE — The attached Official Package Circular provides complete information on the indications, dosage, and precautions for the use of STAPHCILLIN. If you desire additional information concerning clinical experiences with STAPHCILLIN, the Medical Department of Bristol Laboratories is at your service. You may direct your inquiries via collect telephone call to New York, PLaza 7-7061, or by mail to Medical Department, Bristol Laboratories, 630 Fifth Ave., N. Y. 20, N. Y.

BRISTOL LABORATORIES · SYRACUSE, NEW YORK
Division of Bristol-Myers Company

ANNOUNCING—
SPECIFICALLY FOR
INFECTIONS DUE TO
"RESISTANT" STAPHYLOCOCCI

AN ENTIRELY NEW SYNTHETIC
"STAPH-CIDAL" PENICILLIN

Staphcillin™

sodium dimethoxyphenyl penicillin
FOR INJECTION

UNIQUE—BECAUSE IT
RETAINS ANTIBACTERIAL
ACTIVITY IN THE PRESENCE OF
STAPHYLOCOCCAL PENICILLINASE
WHICH INACTIVATES
OTHER PENICILLINS

Bristol

NEW SYNTHETIC PENICILLIN FOR "RESISTANT" STAPH

CUT HERE FOR FILING

November, 1960

STAPHCILLIN™

(sodium dimethoxyphenyl penicillin)

For Injection

DESCRIPTION

STAPHCILLIN is a unique new synthetic parenteral penicillin produced by Bristol Laboratories for the specific treatment of staphylococcal infections due to resistant organisms. Its uniqueness resides in its property of resisting inactivation by staphylococcal penicillinase. It is active against strains of staphylococci which are resistant to other penicillins.

Each dry filled vial contains: 1 Gm. STAPHCILLIN (sodium dimethoxyphenyl penicillin), equivalent to 900 mg. dimethoxyphenyl penicillin activity.

INDICATIONS

STAPHCILLIN is recommended as specific therapy only in infections due to strains of staphylococci resistant to other penicillins, e.g.:

Skin and soft tissue infections: cellulitis, wound infections, carbuncles, pyoderma, furunculosis, lymphangitis and lymphadenitis.

Respiratory infections: staphylococcal lobar or bronchopneumonia, and lung abscesses combined with indicated surgical treatment.

Other infections: staphylococcal septicemia, bacteremia, acute or subacute endocarditis, acute osteomyelitis and enterocolitis.

Infections due to penicillin-sensitive staphylococci, streptococci, pneumococci and gonococci should be treated with Syncillin® or parenteral penicillin G rather than STAPHCILLIN. Treponemal infections should be treated with parenteral penicillin G.

DOSAGE AND ADMINISTRATION

STAPHCILLIN is well tolerated when given by deep intragluteal or intravenous injection.

As is the case with other antibiotics, the duration of therapy should be determined by the clinical and bacteriological response of the patient. Therapy should be continued for at least 48 hours after the patient has become afebrile, asymptomatic and cultures are negative. The usual duration has been 5-7 days.

Intramuscular route: The usual adult dose is 1 Gm. every 4 or 6 hours. Infants' and children's dosage is 25 mg. per Kg. (approximately 12 mg. per pound) every 6 hours.

Intravenous route: 1 Gm. every 6 hours using 50 ml. of sterile saline solution at the rate of 10 ml. per minute.

**Warning:* Solutions of STAPHCILLIN and kanamycin should not be mixed, as they rapidly inactivate each other. Data on the results of mixing STAPHCILLIN with other antibiotics are being accumulated.

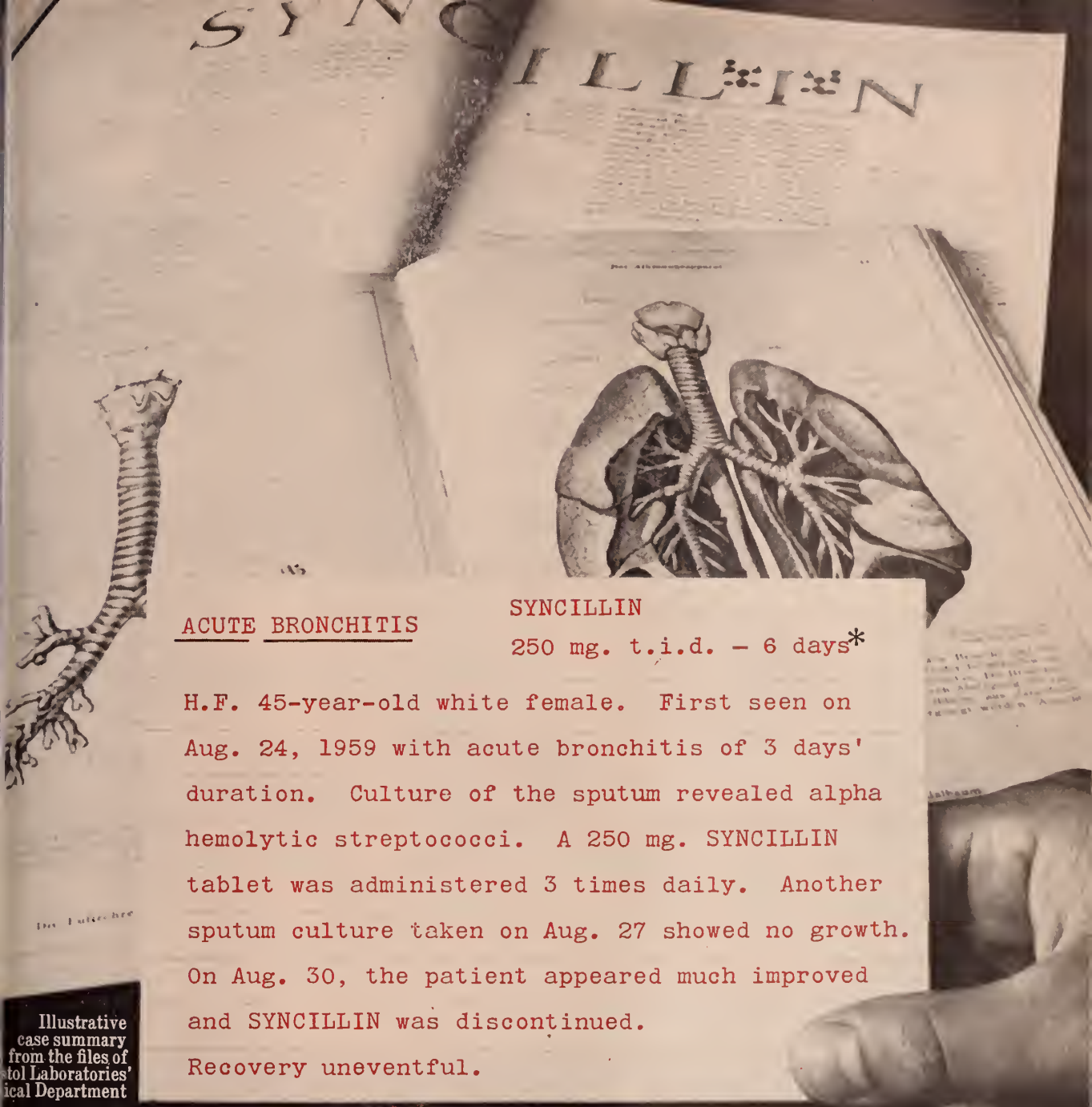
DIRECTIONS FOR RECONSTITUTION

Add 1.5 ml. sterile distilled water or normal saline to a 1 Gm. vial and shake vigorously. Withdraw the clear, reconstituted solution (2.0 ml.) into a syringe and inject. The reconstituted solution contains 500 mg. of STAPHCILLIN per ml. Reconstituted solutions are stable for 24 hours under refrigeration.

For intravenous use, dilute the reconstituted dose in 50 ml. of sterile saline and inject at the rate of 10 ml. per minute.

*This statement supersedes that in the Official Package Circulars dated September and/or October, 1960

(continued)



Illustrative case summary from the files of tol Laboratories' ical Department

THE ORIGINAL phenethicillin

SYNCILLIN®

(phenoxyethyl penicillin potassium)

FIRST SYNTHESIZED AND MADE AVAILABLE BY BRISTOL LABORATORIES

A dosage form to meet the individual requirements of patients of all ages in home, office, clinic, and hospital:

Syncillin Tablets – 250 mg. (400,000 units)...Syncillin Tablets – 125 mg. (200,000 units)

Syncillin for Oral Solution – 60 ml. bottles – when reconstituted, 125 mg. (200,000 units) per 5 ml.

Syncillin Pediatric Drops – 1.5 Gm. bottles. Calibrated dropper delivers 125 mg. (200,000 units)

*Streptococcal infections should be treated for at least 10 days to prevent the development of rheumatic fever and as prophylaxis against bacterial endocarditis in susceptible patients.

Complete information on indications, dosage and precautions is included in the circular accompanying each package.

BRISTOL LABORATORIES, Div. of Bristol-Myers Co., SYRACUSE, N.Y.

Lifts depression..

You see an improvement within a few days
Thanks to your prompt treatment and the smooth action of Deprol, her depression is relieved and her anxiety and tension calmed – *often in a few days.* She eats well, sleeps well and soon returns to her normal activities.

as it calms anxiety!

Smooth, balanced action lifts depression as it calms anxiety... rapidly and safely

Balances the mood — no "seesaw" effect of amphetamine-barbiturates and energizers. While amphetamines and energizers may stimulate the patient —*they often aggravate anxiety and tension.*

And although amphetamine-barbiturate combinations may counteract excessive stimulation—*they often deepen depression.*

In contrast to such "seesaw" effects, Deprol's smooth, *balanced* action lifts depression as it calms anxiety—both at the same time.

Acts swiftly — the patient often feels better, sleeps better, within a few days. Unlike the delayed action of most other antidepressant drugs, which may take two to six weeks to bring results, Deprol relieves the patient quickly — often within a few days. Thus, the expense to the patient of long-term drug therapy can be avoided.

Acts safely — no danger of liver damage. Deprol does not produce liver damage, hypotension, psychotic reactions or changes in sexual function—frequently reported with other antidepressant drugs.

Bibliography *(13 clinical studies, 858 patients)*: **1.** Alexander, L. (35 patients): Chemotherapy of depression — Use of meprobamate combined with benactyzine (2-diethylaminoethyl benzilate) hydrochloride. J.A.M.A. 166:1019, March 1, 1958. **2.** Bateman, J. C. and Carlton, H. N. (50 patients): Meprobamate and benactyzine hydrochloride (Deprol) as adjunctive therapy for patients with advanced cancer. Antibiotic Med. & Clin. Therapy 6:648, Nov. 1959. **3.** Beerman, H. M. (44 patients): The treatment of depression with meprobamate and benactyzine hydrochloride. Western Med. 1:10, March 1960. **4.** Bell, J. L., Tauber, H., Santy, A. and Pulito, F. (77 patients): Treatment of depressive states in office practice. Dis. Nerv. System 20:263, June 1959. **5.** Breitner, C. (31 patients): On mental depressions. Dis. Nerv. System 20:142, (Section Two), May 1959. **6.** Gordan, P. E. (50 patients): Deprol in the treatment of depression. Dis. Nerv. System 21:215, April 1960. **7.** Landman, M. E. (50 patients): Clinical trial of a new antidepressive agent. J. M. Soc. New Jersey. In press, 1960. **8.** McClure, C. W., Popos, P. N., Speare, G. S., Palmer, E., Slattery, J. J., Kanefal, S. H., Henken, B. S., Wood, C. A. and Ceresio, G. B. (128 patients): Treatment of depression — New technics and therapy. Am. Pract. & Digest Treat. 10:1525, Sept. 1959. **9.** Penningtan, V. M. (135 patients): Meprobamate-benactyzine (Deprol) in the treatment of chronic brain syndrome, schizophrenia and senility. J. Am. Geriatrics Soc. 7:656, Aug. 1959. **10.** Rickels, K. and Ewing, J. H. (35 patients): Deprol in depressive conditions. Dis. Nerv. System 20:364, (Section One), Aug. 1959. **11.** Ruchwarger, A. (87 patients): Use of Deprol (meprobamate combined with benactyzine hydrochloride) in the office treatment of depression. M. Ann. District of Columbia 28:438, Aug. 1959. **12.** Settel, E. (52 patients): Treatment of depression in the elderly with a meprobamate-benactyzine hydrochloride combination. Antibiotic Med. & Clin. Therapy 7:28, Jan. 1960. **13.** Splitter, S. R. (84 patients): Treatment of the anxious patient in general practice. J. Clin. & Exper. Psychopath. In press, April-June 1960.

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate. **Supplied:** Bottles of 50 light-pink, scored tablets. Write for literature and samples.

Deprol®

WALLACE LABORATORIES / *Cranbury, N. J.*

CD-2843

As a safe, reliable adjunct to treatment of conditions related to fluid and electrolyte imbalance, specify Kalak® Water

Increasing recognition is being given to the value of establishing and maintaining the physiologic balance of electrolytes in body fluids—as an adjunct to specific medical and surgical therapy and to treatment of many types of disease states. Competent investigators have emphasized the advantages of balanced electrolyte solutions over single-salt solutions. Current medical literature supports the view that electrolytes and fluids be given orally whenever possible to avoid the risks associated with parenteral administration.

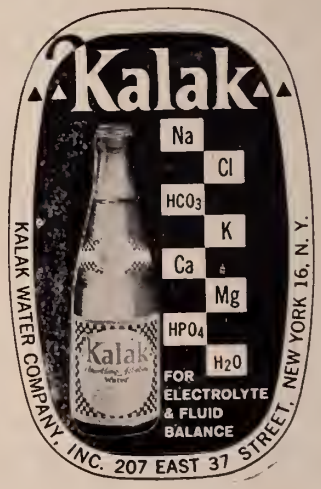
Oral electrolyte therapy acceptable to patients of all ages can be obtained with Kalak Water – formulated under scientific controls to provide essential electrolytes in polyionic association. Kalak has a base of sparkling, crystal-clear distilled water. It is highly palatable when properly cooled, or with added fruit juices or carbohydrates to increase caloric intake.

The table below shows a comparison between plasma and Kalak – available to patients at better food and drug stores.

mEq per liter	Na	Cl	HCO_3	K	Ca	Mg	HPO_4
Plasma	140	103	27	5	5	3	2
KALAK	103	22	100	4.3	12.7	2.7	2.8

a palatable oral solution
of electrolytes, approximating
physiological balance as in human plasma

Clinical supply and literature available on request.
Kalak Water Company, Inc.
207 East 37 Street, New York 16, N. Y. • MUrray Hill 7-3774



© 1960 by Kalak Water Co., Inc.

specific for tension headache...

FIORINAL®

relieves pain, muscle spasm, nervous tension

rapid action • non-narcotic • economical

"We have found caffeine, used in combination with acetylsalicylic acid, acetophenetidin, and isobutylallylbarbituric acid, [Fiorinal] to be one of the most effective medicaments for the symptomatic treatment of headache due to tension."

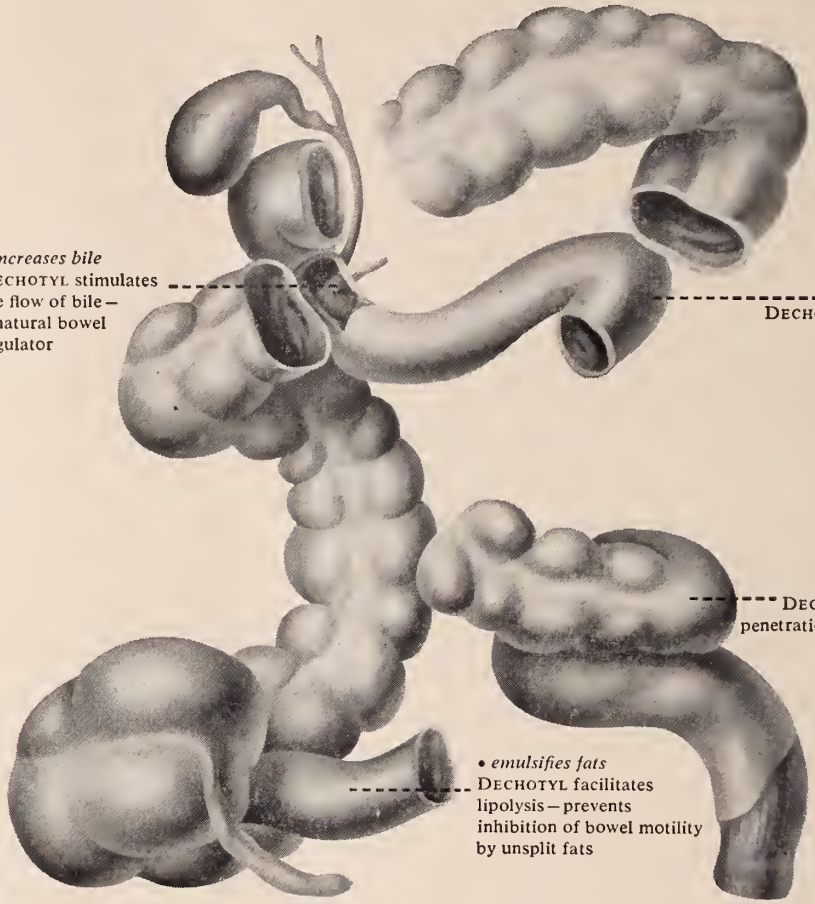
Friedman, A. P., and Merritt, H. H.: J.A.M.A. *163*:1111 (Mar. 30) 1957.

Available: Fiorinal Tablets and New Form — Fiorinal Capsules

Each contains: Sandoptal (Allylbarbituric Acid N.F. X) 50 mg. (3/4 gr.), caffeine 40 mg. (2/3 gr.), acetylsalicylic acid 200 mg. (3 gr.), acetophenetidin 130 mg. (2 gr.).

Dosage: 1 or 2 every four hours, according to need, up to 6 per day.

SANDOZ



helps free your patient from both... constipation and laxatives

DECHOTYL®

TRABLETS*

well tolerated...gentle transition to normal bowel function

Recommended to help convert the patient—naturally and gradually—to healthy bowel habits. Regimens of one week or more are suggested to assure maintenance of normal rhythm and to avoid the repetition of either laxative abuse or constipation.

Average adult dose: Two TRABLETS at bedtime as needed or as directed by a physician. *Action usually is gradual, and some patients may need 1 or 2* TRABLETS *3 or 4 times daily.*

Contraindications: Biliary tract obstruction; acute hepatitis.

DECHOTYL TRABLETS provide 200 mg. DECHOLIN,® (dehydrocholic acid, AMES), 50 mg. desoxycholic acid, and 50 mg. dioctyl sodium sulfosuccinate, in each trapezoid-shaped, yellow TRABLET. Bottles of 100.

*AMES T.M. for trapezoid-shaped tablet.

AMES
COMPANY, INC
Elkhart • Indiana
Toronto • Canada

84160

Bed of Digitalis purpurea
with Campanula (Canterbury Bells) in foreground

Not far from here are manufactured
from the powdered leaf
Pil. Digitalis (Davies, Rose)
0.1 Gram (1½ grains) or 1 U.S.P. Digitalis Unit.
They are physiologically standardized,
with an expiration date on each package.
Being Digitalis in its completeness,
this preparation comprises the
entire therapeutic value of the drug.
It provides the physician with a safe and effective
means of digitalizing the cardiac patient
and of maintaining the necessary saturation.
Security lies in prescribing the
"original bottle of 35 pills, Davies, Rose."

Clinical samples and literature sent to physicians on request

Davies, Rose & Co., Ltd. Boston 18, Mass.

D 27

limit the
blood pressure
swing

Rautrax-N lowers high blood pressure gently, gradually . . . protects against sharp fluctuations in the normal pressure swing. Rautrax-N combines Raudixin, the cornerstone of antihypertensive therapy, with Naturetin, the new, safer diuretic-antihypertensive agent. The complementary action of the components permits a lower dose of each thus reducing the incidence of side effects. The result: Maximum effectiveness, minimal dosage, enhanced safety. Rautrax-N also contains potassium chloride — for added protection against possible potassium depletion during maintenance therapy.

Supply: Rautrax-N — capsule-shaped tablets — 50 mg. Raudixin, 4 mg. Naturetin, and 400 mg. potassium chloride. Rautrax-N Modified — capsule-shaped tablets — 50 mg. Raudixin, 2 mg. Naturetin, and 400 mg. potassium chloride. For complete information write Squibb, 745 Fifth Avenue, New York 22, N. Y.

new Rautrax-N*

Squibb Standardized Whole Root Rauwolfia Serpentina (Raudixin) and Benzydroflumethiazide (*Naturetin) with Potassium Chloride

Squibb Quality—The Priceless Ingredient

SQUIBB

RAUDIXIN,® RAUTRAX,® AND NATURETIN® ARE SQUIBB TRADEMARKS

Note the two tablets on the shelf above. Left, old-style sugar-coated Dayalets-M®. Right, the same formula, but *Filmtab-coated*—potency's assured, but old-style bulk is cut 30%.

ON COATS:

STYLES CHANGE IN VITAMINS, TOO

Coat styles change—whether it's a blazer or a B-complex vitamin. Not long ago, for instance, "Vitamins by Abbott" were dressed up with a new-style coating—*Filmtab*®.

The most obvious result was a marked reduction in tablet size—up to 30% in some products. The tablets themselves were brilliant in a variety of rainbow colors. They wouldn't chip or stick together in the bottle. All vitamin tastes and odors—gone.

Such were the aesthetic gains. Behind these, a significant pharmaceutical advance: with Filmtab, deterioration is slowed to an irreducible minimum, because the coating process is essentially a water-free procedure.

Finally—most important—Filmtab guarantees that the content of each tablet matches the formula printed on the label. While the person taking the vitamins may not worry much about rigid stability, Abbott does. *Assures* it, through Filmtab.

In short, Filmtab's a name that stands for quality, stability, potency. The very best in vitamin coatings. Filmtab doesn't add a penny to the cost. And it's a name found *only* on

VITAMINS by ABBOTT

NEWEST
NUTRITIONAL
PRODUCT
FROM ABBOTT

To meet special nutritional needs of growing teenagers...

Filmtab® **DAYTEENS**
TRADEMARK

- RICH IN IRON, CALCIUM, VITAMINS—IMPORTANT FACTORS FOR THE GROWTH YEARS
- FILMTAB-COATED TO CUT SIZE AND ASSURE FULL POTENCY
- HANDSOME TABLE BOTTLES AT NO EXTRA COST (100-SIZE)
- ALSO SUPPLIED IN BOTTLES OF 250 AND 1000.

NOW, DAYTEENS JOINS THE COMPLETE LINE OF QUALITY VITAMINS BY ABBOTT:

FILMTAB
DAYALETS®
Table bottles of 100
Bottles of 50 and 250

FILMTAB
DAYALETS-M®
Apothecary bottles of 100 and 250

Extra-potent maintenance formulas—ideal for the "nutritionally run-down"

FILMTAB
OPTILETS®
FILMTAB
OPTILETS-M®
Table bottles of 30 and 100
Bottles of 1000

Therapeutic formulas for more severe deficiencies—illness, infection, etc.

FILMTAB
SUR-BEX® with C
Table bottle of 60
Bottles of 100, 500 and 1000

Therapeutic formula of the essential B-complex plus C, for convalescence, stress, post-surgery, etc.

EACH DAYTEENS FILMTAB* REPRESENTS

Vitamin A	(5000 units) 1.5 mg
Vitamin D	(1000 units) 25 mcg
Thiamine Mononitrate (B_1)	2 mg
Riboflavin (B_2)	2 mg
Nicotinamide	20 mg
Pyridoxine Hydrochloride	0.5 mg
Vitamin B_{12} (as cobalamin concentrate)	2 mcg
Calcium Pantothenate	5 mg
Ascorbic Acid (C)	50 mg
Iron (as sulfate)	10 mg
Copper (as sulfate)	0.15 mg
Iodine (as calcium iodate)	0.1 mg
Manganese (as sulfate)	0.05 mg
Magnesium (as oxide)	0.15 mg
Calcium (as phosphate)	250 mg
Phosphorus (as calcium phosphate)	193 mg

VITAMINS by ABBOTT

*FILMTAB—FILM-SEALED TABLETS, ABBOTT

© 1960, ABBOTT LABORATORIES 0090338

ABBOTT

IN COLDS AND SINUSITIS— THE RIGHT AMOUNT OF "INNER SPACE" RIGHT AWAY

Neo-Synephrine hydrochloride relieves the boggy feeling of colds immediately and safely, without causing systemic toxicity or chemical harm to nasal membranes. Turbinates shrink, sinus ostia open, ventilation and drainage resume, and mouth-breathing is no longer necessary.

Gentle Neo-Synephrine shrinks nasal membranes for from two to three hours without stinging or harming delicate respiratory tissues. Post-therapeutic turgescence is minimal. Neo-Synephrine does not lose its effectiveness with repeated applications nor does it cause central nervous stimulation, jitters, insomnia or tachycardia.

Neo-Synephrine solutions and sprays produce shrinkage of tissue without interfering with ciliary activity or the protective mucous blanket.

For wide latitude of effective and safe treatment, Neo-Synephrine hydrochloride is available in nasal sprays for adults and children; in solutions from ⅛% to 1%; and in aromatic solution and water soluble jelly.

Winthrop LABORATORIES
New York 18, N. Y.

NEO-SYNEPHRINE®
(Brand of phenylephrine hydrochloride)
hydrochloride
NASAL SOLUTIONS AND SPRAYS

"Gratifying" relief from

for your patients with
'low back syndrome' and
other musculoskeletal disorders

POTENT muscle relaxation
EFFECTIVE pain relief
SAFE for prolonged use

stiffness and pain

"gratifying" *relief from stiffness and pain in 106-patient controlled study*

(as reported in J.A.M.A., April 30, 1960)

"Particularly gratifying was the drug's [SOMA's] ability to relax muscular spasm, relieve pain, and restore normal movement . . . Its prompt action, ability to provide objective and subjective assistance, and freedom from undesirable effects recommend it for use as a muscle relaxant and analgesic drug of great benefit in the conservative management of the 'low back syndrome'."

Kestler, O.: Conservative Management of "Low Back Syndrome", J.A.M.A. 172: 2039 (April 30) 1960.

FASTER IMPROVEMENT—79% complete or marked improvement in 7 days (Kestler)

EASY TO USE—Usual adult dose is one 350 mg. tablet three times daily and at bedtime.

SUPPLIED: 350 mg., white tablets, bottles of 50.
For pediatric use, 250 mg., orange capsules, bottles of 50.

Literature and samples on request.

SOMA®

(CARISOPRODOL, WALLACE)

WALLACE LABORATORIES, CRANBURY, NEW JERSEY

Diet or Drugs?

In the long term control of serum cholesterol, dietary therapy can achieve the objective in the manner most closely approximating physiological norm.

The long term control of elevated serum cholesterol through changes in the dietary pattern of the patient puts nature's own process to work most effectively to achieve the objectives of treatment. Here are the beneficial features of dietary therapy:

Offers a solution to the related problems of obesity.

Involves little or no added expense to the patient.

May be used with complete safety.

Produces no adverse side effects.

Preferable for the long-term management of a chronic condition.

Brings about reduction of serum cholesterol through physiological processes, as yet not fully understood.

Does not usually generate new compounds in the blood, thus helping the doctor make a more accurate analysis of blood serum cholesterol.

Elevated serum cholesterol has now been linked to an imbalance in the ratio of the type of fat in the diet. Reductions in cholesterol levels have been achieved repeatedly, both in medical research and practice, through the control of total calories and through the replacement of an appreciable percentage of saturated fat by poly-unsaturated vegetable oil.

An important measure in achieving replacement is the consistent use of poly-unsaturated pure vegetable oil in food preparation in place of saturated fat.

Free Wesson recipes for delicious main dishes, desserts and salad dressings are available for your patients. Request quantity needed from The Wesson People, Dept. N, 210 Baronne S

Poly-unsaturated Wesson is unsurpassed by any readily available brand, where a vegetable (salad) oil is medically recommended for a cholesterol depressant regimen.

Wesson is poly-unsaturated . . . never hydrogenated

More acceptable to patients. Wesson is preferred for its supreme delicacy of flavor, increasing the palatability of food without adding flavor of its own.

Uniformity you can depend on. Wesson has a poly-unsaturated content better than 50%. Only the lightest cottonseed oils of high iodine number are selected for Wesson, and no significant variations are permitted in the 22 exacting specifications required before bottling.

Economy. Wesson is consistently priced lower than the next largest seller.

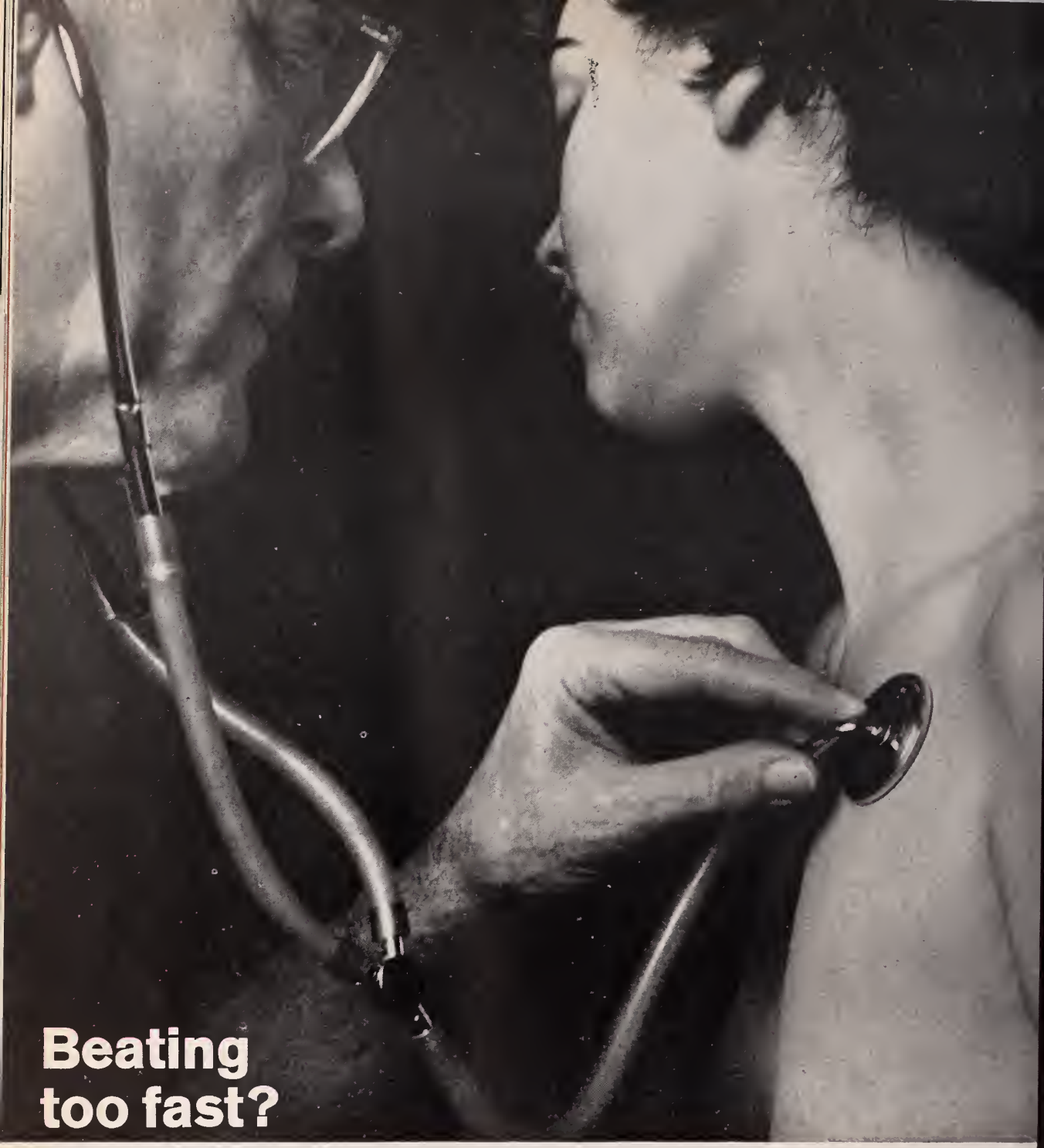
eans 12, La.

WESSON'S IMPORTANT CONSTITUENTS

Wesson is 100% cottonseed oil...winterized and of selected quality

Linoleic acid glycerides (poly-unsaturated)	50-55%
Oleic acid glycerides (mono-unsaturated	16-20%
Total unsaturated	70-75%
Palmitic, stearic and myristic glycerides (saturated)	25-30%
Phytosterol (Predominantly beta sitosterol)	0.3-0.5%
Total tocopherols	0.09-0.12%

Never hydrogenated—completely salt free



Beating too fast? Slow it down with SERPASIL®

(reserpine CIBA)

Serpasil has proved effective as a heart-slowing agent in the following conditions: mitral disease; myocardial infarction; cardiac arrhythmias; neurocirculatory asthenia; thyroid toxicosis; excitement and effort syndromes; cardiac neurosis; congestive failure. Serpasil should be used with caution in patients receiving digitalis and quinidine. It is not indicated in cases of aortic insufficiency.

SUPPLIED: Tablets, 0.1 mg., 0.25 mg. (scored) and 1 mg. (scored). Complete information available on request.

CIBA

SUMMIT • NEW JERSEY

NEW PROFESSIONAL LIABILITY INSURANCE PROGRAM APPROVED BY YOUR MEDICAL SOCIETY

American Mutual has been appointed by the 1960 House of Delegates of The Medical Society of New Jersey to provide your professional liability insurance. (See article in August JOURNAL, page 497.)

This means protection by the *first* American liability insurance company. Long experience in the field of professional liability insurance has led to a practical solution of one of the important problems—that of *loss control*—faced by the medical profession.

Insurance for Professional Liability and Professional Premises Liability is available to members of The Medical Society of New Jersey. Professional Liability Insurance is also available to the registered nurses and qualified technicians employed by our policyholder doctors.

Protection for Libel, Slander and Defamation of Character arising out of activities on committees of State and County Medical Societies and committees of licensed hospitals is furnished to all insured doctors.

Please address your request for further information about this program to:

American Mutual Liability Insurance Company

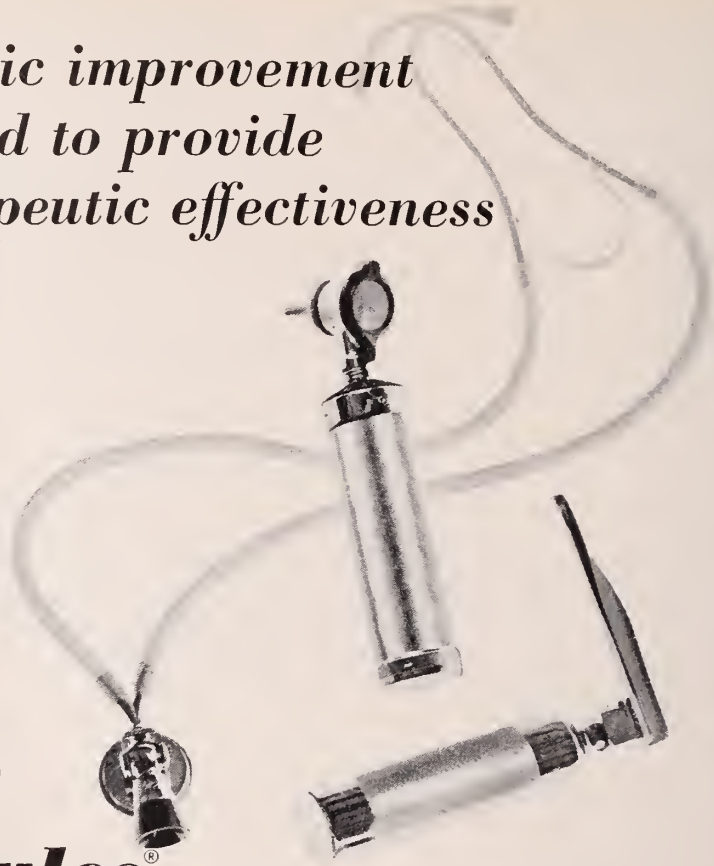
PROFESSIONAL LIABILITY DEPARTMENT

68 SOUTH HARRISON STREET EAST ORANGE, NEW JERSEY

JOSEPH A. BRITTON, Manager ORANGE 3-2575

HOME OFFICE: WAKEFIELD, MASS.

an antibiotic improvement designed to provide greater therapeutic effectiveness



now Pulvules® Ilosone®

(propionyl erythromycin ester lauryl sulfate, Lilly)

in a more acid-stable form assure adequate absorption even when taken with food

Ilosone retains 97.3 percent of its antibacterial activity after exposure to gastric juice (*p*H 1.1) for forty minutes.[1] This means there is more antibiotic available for absorption—greater therapeutic activity. Clinically, too, Ilosone has been shown[2,3] to be decisively effective in a wide variety of bacterial infections—with a reassuring record of safety.[4]

Usual dosage for adults and for children over fifty pounds is 250 mg. every six hours.
Supplied in 125 and 250-mg. Pulvules and in suspension and drops.

1. Stephens, V. C., *et al.*: J. Am. Pharm. A. (Scient. Ed.), *48*:620, 1959.
2. Salitsky, S., *et al.*: Antibiotics Annual, p. 893, 1959-1960.
3. Reichelderfer, T. E., *et al.*: Antibiotics Annual, p. 899, 1959-1960.
4. Kuder, H. V.: Clin. Pharmacol. & Therap., in press.

Lilly
QUALITY / RESEARCH / INTEGRITY

ELI LILLY AND COMPANY • INDIANAPOLIS 6, INDIANA, U.S.A.

032644

THE JOURNAL
OF
THE MEDICAL SOCIETY OF NEW JERSEY

Editorials • • •

The Concept of "Normal"

Since nobody is perfect, it is not normal to be perfect. Is a patient normal if the only thing wrong is 20/30 vision in one eye? If his only blemish is a slight case of athlete's foot between two toes? Or if he is 5 pounds overweight?

What is "normal" anyway? Actually there are five possible definitions: (1) Normal is what is culturally acceptable. Heterosexuality is normal; homosexuality is not. Obeying the law is normal under this concept. (2) Normal is the statistical average. By this yardstick, it is normal to drive faster than the speed limit; normal to park in a no-parking area. By this standard, normal weights are higher in the U.S.A. than in China. If it were shown that the average of systolic blood pressure of all 50-year old men was, say, 170, then 170 would be the normal systolic blood pressure for this group. (3) Normal is the ideal. If you do not conform to the height-weight tables, then you are not normal. It is not normal to wear eyeglasses or dentures by this concept. (4) Normal is the traditional. A few winters ago, it was not normal for women to wear slacks; a few summers ago it was not normal for them to wear shorts. The norms have changed. (5) Normal is the absence of any finding of disease. An x-ray report that the chest is normal would come under this definition.

Anyone concerned with child rearing will know how plastic the concept of normal is. Is it normal for children to cry, or wet themselves at the age of 18 months? Is it normal for children to be afraid of thunder or for

PUBLISHED MONTHLY SINCE 1904
Under the direction of the Committee on Publication
FRED B. ROGERS, M.D., *Chairman*

HENRY A. DAVIDSON, M.D., *Editor*
MIRIAM N. ARMSTRONG, *Assistant Editor*

Place of Publication, Printing and Mailing—116 Lincoln Avenue, Orange, N. J.
Editorial and Executive Offices of the Society—315 West State Street, Trenton 8, N. J.
Send all communications for publication to P.O. Box 904, Trenton 5, N. J. — Telephone EXport 4-3154
Each paying member of the State Society is entitled to receive a copy of THE JOURNAL every month
Whole Number of Issues 676

VOL. 57, NO. 12 DECEMBER, 1960 Subscriptions, $3.00 per Year
Single Copies, 30 Cents

parents to feed them whenever they are hungry.

The slipperiness of the concept of "normal" makes our work more difficult. Patients always want to know whether their blood pressure or blood counts are "normal." New mothers want to know whether the just-delivered infant is "normal." Health and life insurance companies hesitate to insure people who show abnormalities, though they are not certain how to measure "normal."

We have had to abandon the ideal of "excellence" as the norm, since under the ancient criteria no one would be normal. Shall we ever again return to a state of innocence when padding an expense account is "abnormal?" Shall we ever have many people so radiantly healthy that the most meticulous examination will disclose no carious tooth, no deviation from the weight-height table, no flat feet?

How much daily (or weekly) consumption of alcohol, or tobacco, is normal? Is it normal to drive to the corner store instead of to walk there? Is a pulse of 86 normal? Normal, let's face it, is a myth. There are at least five definitions, and an imaginative observer can dream up a few more. If none can define it, few can achieve it. Certainly it is not absolute. When asked: "Are the findings normal?" we have a right to answer: "For what set of circumstances?"

Influenza is Still a Problem

While the great pandemic of 1918 is only a grim memory, influenza is still with us. A recent report (U. S. Public Service Reports, October 1960) tells us that influenza swept the United States in 1957-8, resulting in 60,000 *more* deaths than were statistically expected. And figures show 26,000 *excess* deaths during the first three months of 1960 alone.

These departures from the norms prompted the Surgeon General's Advisory Committee to seek measures to prevent such an occurrence in the future.

The committee found that a new Asian strain was the direct cause of the excess number of deaths, not only in the total population but most markedly among the chronically ill, the aged, and pregnant women. As a result the Public Health Service is urging a continuing program to protect these high-risk groups.

The high-risk groups who contribute most to the excess deaths and who the Public Health Service believes should be routinely immunized each year include all pregnant women, all persons over the age of 65, all diabetics, cardiacs, hypertensives and victims of chronic debilitating disease.

The adult dosage recommended by the advisory committee for initial immunization is 1.0 cubic centimeters (500 cca units) of polyvalent vaccine, administered subcutaneously on two occasions separated by two or more months. Persons previously immunized with polyvalent vaccine should be reinoculated with a single booster dose of 1.0 cubic centimeter subcutaneously each fall. The only contraindication to vaccination would be a history of food allergy to eggs or chicken or a prior history of allergic reaction to an egg-produced vaccine, such as the commercial influenza product.

The time to start such a program is now. In the past, influenza vaccination has been sparse and sporadic, and primarily in response to the threat of an epidemic. The unpredictability of influenza and its continued endemic occurrence are well known. The Public Health Service strongly recommends that immunization of these high-risk groups be started *now* and continued annually, regardless of the predicted incidence of influenza for specific years.

Original Articles • • •

RICHARD E. GORDON, M.D., *et al.**

Englewood

Coronary Artery Disease in a Rapidly Growing Suburb

Lest we forget that medicine is a social science as well as a biologic science, studies like this are needed. It is not true that coronary disease and peptic ulcer are disabilities of the "upper" classes only. As Dr. Gordon and his colleagues show here, those in the lower half of the economic spectrum tend to have more serious illnesses.

THIS study investigated social, economic and psychologic features in patients who survived and in those who succumbed to coronary artery disease. Similar data from patients with emotional difficulties and with peptic ulcer were obtained for comparison. The rapid social changes and mobility of modern life may be related to coronary artery disease, psychosomatic disorders and emotional illnesses. Individuals in more stressful social situations may be more susceptible to these diseases. Prognosis may be worse when the social environmental situation is such that stresses cannot readily be relieved.

Coronary artery disease has been reported to be related to: (1) Physiologic and organic factors; (2) Psychologic factors; (3) Sociologic and economic features. Some of the physiologic and organic features included body type, heredity, weight, diet, lack of exercise, phospholipid, cholesterol, and uric acid metabolisms. Numerous emotional factors have been implicated including: "full speed ahead attitude," personality drive, ambitiousness, intelligence, and inability to relax and enjoy leisure. The social and economic features reported included social rising or declining in a changing world and competitive environmental situations that chronically mobilize tension. This paper will examine additional evidence to support the thesis that this third (social and economic) grouping may have considerable importance in coronary artery disease.[1,3,4,9,11,13,16,18,19,20,21,23]

Each of these three levels of scientific investigation may be related in part to the other. On the constitutional, biochemical and physiologic levels, a chronic tendency to strain oneself may be associated with augmented adrenocortical function, high blood cholesterol and the skeletal and muscular development of the mesomorph. In the "social" area, an individual who is striving to "get ahead" and achieve "status" rapidly may overinvolve himself in work, family, educational and community responsibilities. He may also overextend himself with debts and obligations for his home, cares, and appliances. These obligations may trap him into life situations that place demands upon him to keep working and earning, to meet deadlines, that key him up, and prevent him from relaxing and playing. They may keep his emotional and physiologic emergency mechanisms chronically "straining."

*Co-authors are John E. McWhorter, M.D., Marcia G. Singer, M.A., and Katherine K. Gordon, B.S. This work is from the Englewood Hospital, Englewood, N. J. Mrs. Prudence Burgess, Mrs. Marcia Lucas and Miss Jean Tilt assisted in the performance of this study. It was supported (in part) by grants from the Trubek Fund and the Mitchell Cinader Research Foundation.

Psychologically alert, intelligent people may have higher serum levels of uric acid and may lead more stimulating and enriched lives, which, in turn, help them become brighter. (An interesting question arises—when does an alert "driving" attitude, often associated with higher intelligence, become a danger to health?)

The children of coronary diseased parents may not only inherit their parents' genetic endowment, but may acquire, by example, precept, encouragement and expectation, their drive and ambition. These patients, perhaps, react to stresses (unfortunate experiences, usually with parents in early life, and/or with spouse, employer, others, or economics, in later life) by continuing to struggle and drive themselves. They may strive to combat, surmount, and overcome obstacles by extreme and long-continued, but not necessarily successful effort.

A series of studies[5-10] have provided data which indicate relationships between certain social factors such as socio-economic position, suburban migration, education, ethnic origin, intelligence and other variables—with need for and responsiveness to psychotherapy and preventive psychiatry. This report will also present data regarding patterns of suicides and will examine and analyze more intensively data from psychiatric and psychosomatic patients. Correlations and intercorrelations between these above mentioned variables may lead to better understanding of the medical and psychologic effects of the fast pace of rapidly changing modern life.

PROCEDURE

Over 500 records were obtained of diagnosed coronary disease and peptic ulcer patients from the Englewood Hospital. This hospital serves a rapidly growing group of communities in Bergen County, New Jersey.

The patients chosen for study were all under 65 years of age. They were treated by many different physicians. Diagnostic criteria varied with each physician. One of us (John E. McWhorter, M.D.) set up standard objective criteria for coronary artery disease. Duodenal ulcer cases were included only when there was demonstrable ulcer by x-ray.

Seventy cardiacs and fifty-four ulcer patients met the criteria and were still alive six months later. These patients' records were analyzed for psychosocial data. Similar data were also compiled from records of 128 coronary artery disease subjects, 65 years of age or less, who did not survive their hospital stay.

Records were studied on coronary disease and peptic ulcer patients who were admitted to Olean (N.Y.) General Hospital during the same period. This hospital serves a slow-growing, predominantly rural community. Economic and social status was classified by the method used and reported in previous studies, using a modified Hollingshead scale.[7]

The norms used for camparison of psychosocial data were 335 Englewood Hospital and 88 Olean General Hospital obstetrical patients and their husbands. For statistical clarity chi-square was determined. Only statistically significant data† are presented. The contingency coefficient was calculated as a measure of correlation. No effort was made to control for diet, weight, heredity, therapeutic approach or other metabolic, physiologic, or genetic variables.

RESULTS

Patients who survived an acute cardiovascular accident for six months were significantly different in social backgrounds than those who were less fortunate. (See Tables 1 and 2.) Major features of their differences were:

(1) Among those who survived at least six months, the self-employed, professional and managerial class patients tended to have significantly *more coronary attacks and at younger ages.* Skilled laborers who had attacks tended to be older. The intervening social and economic group was intermediate in age.

(2) Socially and economically higher and geographically more mobile ethnic groups (particularly younger patients of the Jewish faith, who are significantly more upwardly mobile newcomers

†Findings that would have occurred by chance less often than once in twenty times.

TABLE 1.

SOCIOLOGIC FACTORS IN CORONARY DISEASE

Comparison of Social Psychologic Features in Lives of 128 Coronary Artery Disease Patients Who Died and 62 Who Survived Six Months or More After Admission to the Englewood Hospital

Age	Economic and Social Position	Died Per Cent	Survived Per Cent
Under 44	Upper middle	0	10
	Middle middle	2	11
	Lower middle	2	3
	Lower	2	0
		6	24
45-49	Upper middle	2	3
	Middle middle	4	10
	Lower middle	2	6
	Lower	1	0
		9	19
50-54	Upper middle	4	5
	Middle middle	4	10
	Lower middle	6	13
	Lower	2	2
		16	30
55-59	Upper middle	1	2
	Middle middle	11	8
	Lower middle	11	6
	Lower	6	3
		29	19
60-65	Upper middle	2	2
	Middle middle	14	0
	Lower middle	19	5
	Lower	6	2
		41	9
Religion	Jewish	10	23
	Catholic	36	44
	Protestant	54	33
Birthplace	Foreign	21	16
	Bergen Co.	11	0
	U.S. (not Bergen Co.)	68	84

Patients of higher social classes tended significantly more than those of lower classes to be hospitalized for coronary disease at younger ages. But those with better socio-economic positions tended significantly to survive.

Jewish patients, mostly upwardly mobile newcomers, tended to survive while the Bergen County born, usually socio-economically stable or declining, did not.

TABLE 2.

OCCUPATIONS OF PATIENTS WITH CORONARY ARTERY DISEASE

Executives, Professional Persons, Managers and Owners	Aged 65 or Less Lived	Aged 65 or Less Died	Aged 54 or Less Lived	Aged 54 or Less Died
Merchants and Retail Store Owners	11	0	10	0
Brokers, Bankers and Executives in Large Firms	10	3	9	2
Sales and Insurance	13	11	9	4
Real Estate	2	0	1	0
Small Business Owners	3	7	2	3
Lawyers and Accountants	2	6	2	6
Construction	1	4	1	3
Small Business Managers	1	14	1	7
Total	43	45	35	25
Employees and Laborers				
Operators and Laborers	17	27	11	3
Bookkeepers, Secretaries and Clerks	1	12	1	3
Superintendents, Inspectors, Supervisors, Chiefs	1	14	1	5
Total	19	53	13	11

Note—Executives, professional persons, managers and owners as a group were significantly *more likely to survive* than employees and laborers.

to Bergen County) had an earlier and higher morbidity.

(3) Economic, social and ethnic features were significantly correlated with each other.

(4) Higher social and economic position was associated with survival, particularly among the younger cardiac patients. Newcomers tended to survive. Longer-residents did not tend to get early attacks but were significantly less likely to survive.

Comparable conclusions may be drawn from the data of patients seeking help for emotional problems, for whom data have previously been published.[5-10] Among 129 expectant mothers seeking antenatal class guidance and 516 psychiatric outpatients requiring psychotherapy, social psychologic features were again significantly correlated:

(1) Higher economic groups sought help more readily.

(2) The main upwardly mobile newcomer group to the Bergen County area, those of Jewish religious background, predominated.

(3) Ethnic features, suburban migration, education and intelligence were significantly intercorrelated with each other.

(4) These correlated features were related to therapeutic response.

Newcomers to the community, patients with highest I.Q.s, best educations, and in higher economic and social categories responded best.

These same patterns had previously been observed when parents brought their children for psychotherapy,[8] and when husbands cooperated in helping their wives to adjust.[5,6]

Significantly more housewives with coronary artery disease tended to die than did men of all ages under 65. But significantly fewer housewives had coronary attacks under the age of 54. Six women in the study worked outside the home. Three (50 per cent) were under 54 and four (67 per cent) died. These proportions parallel those for working men more than those for housewives, although the numbers of working women are too few to be statistically significant.

Suicides in Bergen County among younger men and women have declined in the years of rapid community growth 1948 to 1956; but fatalities have increased significantly among the middle aged. Middle aged women in particular have tended more to suicide in recent years. (See Table 3.)

Coronary artery disease patients in Olean General Hospital (in rural Cattaragus County, New York) showed a similar age—socio-economic grouping to that found with patients with this disease in Bergen County. Patients, as reported earlier, were older and tended generally to lower economic and social strata, but the age-socio-economic patterning was the same.[9] Younger coronary disease patients tended significantly to be higher economically and socially. Foreign-born patients in Olean General Hospital had significantly more coronary artery disease and peptic ulcer than native born.

On-the-road salesmen and their families tended to have a higher emotional and coronary artery disease morbidity than did the general population. Significantly higher proportions of psychiatric outpatients, ulcer patients and coronary disease patients were drivers of buses, trucks or taxis or members of the families of drivers, as compared to norms. Those who "drive themselves, drive others, and drive vehicles" are prone to peptic ulcer, as has been noted elsewhere.[17]

TABLE 3.

SUICIDES IN TWO ADJACENT COUNTIES

Suicides Absolute Numbers	1948-1950	1951-1953	1954-1956
Bergen County: Men aged 18-44	34	19	20
Bergen County: Men aged 45-64	48	49	52
Bergen County: Women aged 18-44	20	15	11
Bergen County: Women aged 45-64	20	22	34
Essex County: Ages 15-44	111	97	70
Essex County: Ages 45-64	160	108	126

Essex County is slowly growing; Bergen County is growing with great rapidity. In both counties there has been a decline in suicides in persons under the age of 45, when 1954-6 figures are compared with previous years. However, in the middle-aged bracket (ages 45 to 64) the number of suicides has increased in Bergen County but declined in Essex County. Particularly striking has been the burgeoning suicide rate of older women in Bergen County.

Occupations of patients who developed coronary artery disease are shown in Table 2. The managers who had a poor survival rate supervised offices, motels, markets, a meat company, a bowling alley, and a movie theatre. Other businesses, whose owners did not usually survive, included a service station, cleaning establishments, a dairy, a tavern, tailor shops and a photography shop.

Certain types of occupations were much more frequently associated with morbidity and mortality, both among the younger as well as the entire groups of patients. From these findings it might be concluded that the following circumstances were associated with mortality:

1. *Greater supervisory stress.* Supervisors and managers were worse off than workers, operators, and salesmen.

2. *Size of the business.* Executives in large firms (which are generally competing more successfully than smaller businesses) did better than managers and owners of small businesses. Large

firms often can provide better economic and social arrangements for ill executives.

3. *Financial insecurity.* Managers of the small businesses were worse off than owners. Workers, protected by their union plus unemployment and sickness benefits, were better off than supervisors, who often received neither management nor union protection.

4. Necessity for continued direct *personal involvement in the business.* Men in construction work, or running establishments in which they personally provided a service (cleaners, tailors, and so on) did not do as well as merchants. The latter presumably could employ a manager to run the store if they became ill or wanted a vacation.

Ten per cent of Englewood Hospital's proved ulcer cases were reported to have coronary artery disease. Eight per cent of patients with established coronary disease gave a history of duodenal ulcer.

SUMMARY OF RESULTS

THE evidence gathered thus far would indicate that the rapidly advancing socially mobile younger newcomer groups tended to develop coronary artery disease, emotional and psychosomatic disorders earlier. They sought help quickly, and tended to respond satisfactorily. Many less successful individuals were of local birth. Their life situations were more likely associated with chronic frustration and possibly with economic decline. They tended to develop disorders later. But they frequently had more severe emotional and physical problems. They were more likely to succumb from coronary artery disease. Middle-aged men and women in particular were victims of this disease. They also tended to suicide. Other studies [10] have indicated that less competitive single men, the widowed, and divorced, those whose lives may be associated with social decline, frequently responded less favorably to psychologic management.

Apparently, chronic stress and strain are associated with development of coronary artery disease, emotional and psychosomatic disorders. Individuals whose emotional and physical disorders were associated with more readily relievable stresses had better prognosis. Individuals with disorders related to less modifiable stresses, often associated with social decline, had less tractable physical and emotional illnesses and greater mortality.

COMMENT

RUSSEK [19] recently reported that physicians in "high stress" occupations suffered more coronary disease than did those in less stressful specialties. General practitioners and anesthesiologists reported a history of this illness from two to four times more frequently than did dermatologists and pathologists. The present study provides additional evidence of the importance of chronic stress in coronary artery and other diseases.

Multiple features are involved in the etiology of coronary artery disease, emotional and psychosomatic disorders. Chronic stress, associated with the struggle to rise, with trying to hold one's own against tough competition, or with an effort to resist economic or social decline, apparently takes its toll. When more easily modifiable stress (such as that related to upward social mobility) was a factor, prognosis was more favorable. Those who felt they had "arrived" economically and socially, might have higher morale. Those who became ill could "ease up" more readily, reorganize their lives and behavior, apparently with life-saving consequences. Economic situation, education, social mobility, and intelligence were all significantly intercorrelated with each other, as well as with psychologic adjustment.

On the other hand, unmodifiable chronic stresses, such as those related to economic or social decline, were often associated with medical and emotional disasters. Whether an individual was self-employed, in the professions, or worked for others was not a particularly remarkable feature. But his opportunity to extricate himself from the situational stress apparently was important.

The changing nature of rapidly growing Bergen County, with greater social mobility and loosening of family and community ties, tended to decrease the psychologic and econ-

omic security of less rugged individuals. The marginally adjusted, sensitive to repeated threat and injury in a more competitive atmosphere, tended to become demoralized and discouraged. Some became depressed, emotionally upset or physically ill. They felt themselves trapped in a way of life and standard of living they could neither maintain, nor give up. When they became ill, their emotional and psychosomatic disorders were less tractable. They more readily became psychiatric inpatients,[5] who were less frequently discharged.[10] Some tended to suicide and others to develop fatal coronary artery disease.

Problems associated with rapid community change apparently are not limited in the modern world to rapidly growing American suburban communities. Scientists have noted similar medical and emotional by-products of rapid industrialization and concomitant social change in Africa,[12] Russia[14] and Yugoslavia,[23] among other places.

The tendency for housewives to have lower morbidity but higher mortality from coronary artery disease has been noted previously.[24] Reports[7,9,10] have indicated a rising incidence of emotional and psychosomatic disorders in housewives, associated with community mobility. A housewife's emotional state may reflect her husband's adjustment as well as her own social and economic situation. It is thus susceptible to the stresses of community change. Middle-aged women appeared to be more affected than men, perhaps because of the double jeopardy of loss of a significant role in life, when children grow up, and loss of social position if husband's economic security is threatened.

Generally, individuals in more precarious businesses, whose social and economic positions were less secure, were more likely to die. Worst off were those who had to continue at work for economic security, who could not sell out and retire, or hire some one to run the business. The manager in a concern too small to compete very successfully and provide extra security for its employees, the professional man or the owner of a business that does not operate in his absence can less readily relax when instructed by the physician. He cannot afford to become seriously ill. Men whose wages or salaries would continue when they are recuperating apparently lived longer than those who must calculate both the cost and the loss of income and customers. Life not only was more rewarding but healthier for the individual with more power and influence over his economic security, destiny, and pleasures.

There seemed to be a close relationship between coronary disease and duodenal ulcer. This has been reported earlier.[2] Although both processes involve different hereditary and physiologic features, they may both be related to a common factor of chronic stress.

WHAT IS TO BE DONE ABOUT IT?

UPWARDLY mobile people busily getting ahead in life must recognize and respect their physiologic limitations. Hard work never hurt anyone. But proper diet, exercise, leisure, sleep and rest periods free from tension, worry and stress are essential to the maintenance of good health. We physicians cannot repeat this too much to our patients (and to each other). The upwardly mobile apparently are in more of a position to heed our advice *after* their coronary attacks and other stress related illnesses. Why not before?

The less economically, educationally and socially favored have less ready control over their lives and the stresses that affect them. They are more dependent upon outside assistance before they can become masters of their own destinies. Unaided, they have limited ability to heed counsel, readjust their life situations and prevent stress—related illness; their prognosis is quite guarded once disease strikes. Economics, psychology, sociology and medicine all interact unfavorably in these persons' lives. Thought must be given to hard-headed, practical methods at rehabilitating these less fortunate citizens.

One thing is increasingly clear to medical psychologists. Upwardly mobile suburbanites and others—independent, resourceful, intelligent people (yes, physicians too) need each

other to fall back upon in time of emergency. Life is less stressful for the man with reliable, responsible family, business and professional associates and friends. Dependable allies are often as valuable to happiness and security as money in the bank, investment portfolios and insurance policies. Mobile people tend to sever their family, neighborly and community ties. They rush ahead pseudo-independently, sometimes with unfortunate consequences to their and their families' health. Let us certainly encourage independence, but with interdependence in reserve.

SUMMARY

THERE are social and economic features in the lives of patients with coronary artery disease, emotional difficulties and psychosomatic disorders. It is suggested here that economic and social factors are interrelated with physiologic features and with morbidity and mortality.

Better educated, economically "upwardly mobile" persons tended to require earlier assistance for coronary artery disease, psychosomatic disorder, and emotional difficulty. However, these patients tended to respond better to medical and psychiatric treatment. They had lower mortality from coronary artery disease.

Apparently the eonomically or socially better situated could remove the chronic stress associated with illness when necessary. The socially declining had less control over the stresses in their lives and apparently suffered more unfortunate consequences when and if they became ill.

275 Grand Avenue

BIBLIOGRAPHY

1. Billings, F. T., *et al.*: Am. J. Medicine, 7:356, (1949).

2. Bobra, S. T. and Paterson, J. C.: Journal of the Canadian Medical Society, 14:498 (1958).

3. Gertler, M. M. and White, P. D.: *Coronary Heart Disease in Young Adults.* Harvard University Press for the Commonwealth Fund, Boston (1954).

4. Gertler, M. M., *et al.*: J.A.M.A., 176:149 (1959).

5. Gordon, R. E.: A.M.A. Archives of Neurol. and Psychiat., 81:486 (1959).

6. Gordon, R. E.: Am. J. Obs. and Gyne., 15:433 (1960).

7. Gordon, R. E. and Gordon, K. K.: A.M.A. Archives of Neurol. and Psychiat., 79:543 (1958).

8. Gordon, R. E. and Gordon, K. K.: International J. Social Psychiatry, 4:85 (1958).

9. Gordon, R. E. and Gordon, K. K.: J.A.M.A., 170:1757 (1959).

10. Gordon, R. E. and Gordon, K. K.: International J. Social Psychiatry. (In press).

11. Hammarsten, J. F., Cathey, C. W. and Wolf, S.: Journal of Clinical Investigation, 36:897 (1957).

12. Henderson, J.: In *Africa—Social Change and Mental Health.* World Federation for Mental Health, New York, 1959. Page 8.

13. Hinkle, L. E.: The Relation Between "Life Stress" and the Employability of the Cardiac. Conference on Heart in Industry, N. Y. Heart Association. Page 11 (1959).

14. Kesic, B.: Yugoslav Doctor Lists Ills of Era. Reported in N. Y. *Times,* Oct. 11, 1959.

15. Mirsky, J. I.: American Journal of Digestive Diseases, 3:285 (1958).

16. Morris, J. N., *et al.*: Lancet, 265:1053 and 265:1111 (1953).

17. Norman, L. G.: Lancet, 274:807 (1958).

18. Reitman, N.: JOURNAL of The Medical Society of New Jersey, 56:673 (1959).

19. Russek, H. I.: J.A.M.A., 171:503 (1959).

20. Russek, H. I. and Zohman, B. L.: Am. J. Medical Sciences, 235:266 (1958).

21. Southwood, A. R.: Lancet, 276:435 (1959).

22. Stewart, J. M. G.: Lancet, 264:867 (1950).

23. Yanushkevichius, Z. I.: J.A.M.A., 171:655 (1959).

24. Zinn, W. J. and Cosby, R. S.: Am. J. Medicine, 75:169 (1950).

E. P. Gelvin, M.D.

Whippany

Skin Tumor as the Cause of Nodular Chest Density*

Case Report

Before concluding that an abnormal nodular density in a lung field is due to a pulmonary tumor, examine the skin. The finding might be due to a benign skin tumor.

Abnormal x-ray shadows in the lung fields, not belonging anatomically to the lungs and pleura can present the appearance of an actual lung lesion. Summarizing these artifacts Hefke[1] divides them into three categories.

One group consists of shadows not a part of the body, such as clothing, pins, buttons, adhesive tape, and the like. Another group is caused by something belonging to the body but not usually obvious on the chest x-ray. Breast shadows, for instance, can cause difficulties, as can strongly developed pectoral muscles, nipple shadows, heavy scars or skin nodules and tumors. The third group is the result of technical factors such as a fault in the film emulsion, defects in the cassette or intensifying screen, or errors in the developing and fixing process such as allowing two films to touch in the tank, or rough handling of the film resulting in damage to the emulsion. A recent rather common finding has been small spots which appear "light struck," apparently caused by small radioactive particles that got into the package of films in some manner.

The following case illustrates pseudopathology in a routine chest x-ray caused by a skin tumor on the back. The concern derived from this finding was intensified since previous x-rays had never demonstrated such an abnormality.

A 58-year old engineer, was given his routine yearly physical examination on March 2, 1960. He had no subjective complaints aside from occasional episodes of low back discomfort caused by degenerative arthritis of the lumbar spine. Past x-rays had demonstrated hypertrophic changes in the lumbar spine (1952) and a bilateral calcific tendonitis of both shoulders (1946). Routine chest x-rays in 1958 and 1959 were normal. Physical examination did not reveal any significant abnormalities aside from a moderate degree of obesity and small bilateral hydroceles. Laboratory examination included a urine analysis which was normal, sedimentation rate (corrected) 9 millimeters, hematocrit 47 per cent, and serum protein bound iodine 4.6 micrograms per 100 cubic centimeters. The electrocardiogram was normal.

A teleoroentgenogram of the chest taken March 3, 1960, was reported as demonstrating a nodular lesion at the level of the first left intercostal space which was not apparent in the previous film submitted for comparision (Fig. 1). In order better to localize and evaluate this finding, this x-ray was repeated on March 9, 1960 with the addition of apical lordotic and left lateral views. While positioning the patient for these x-rays, a sessile growth about 8 millimeters long and 5 millimeters thick was noted on the left posterior thorax about the level of the previously described density. A second postero-anterior view again revealed the nodu-

*This work is from the Bell Telephone Laboratories, Inc. at Whippany, N. J.

1. Hefke, W. E.: Pseudopathology in Chest Roentgenograms. American Journal of Roentgenol. and Rad. Therapy, 72:29 (1954).

Figure 1. Routine PA view demonstrating a nodular density in the first left anterior interspace.

Figure 2. PA view after surgical removal of the skin tumor. The density is no longer apparent.

lar density in the same location. This density could not be seen in the apical lordotic view. Careful inspection of the left lateral projection revealed an irregularity of the skin of the back which probably represented the skin tumor.

Because of these findings, it was felt reasonably certain that the nodular density seen in the PA projections was extra-pulmonary. However, in order definitely to establish this, the patient was advised to have the tumor of his back removed. This was done by his personal physician on April 2, 1960. A follow-up postero-anterior chest x-ray on April 12, 1960 did not reveal the previously described density (Fig. 2). The pathologic report of the tumor was sclerosing hemangioma, skin of back.

SUMMARY

A SOLITARY nodular density in the left upper lung field suddenly became apparent on a routine chest x-ray. Further study revealed this density to have been an artifact, caused by a skin tumor (sclerosing hemangioma) of the upper left posterior thorax. That this was responsible for the x-ray finding was established by its disappearance after surgical excision of the tumor.

Bell Telephone Laboratories, Inc.

Documentary History of Medicine Film Now Available

A capsule history of medicine from ancient time to the present has been produced by White Laboratories and is available for medical and lay group showings. Title of the film is "69.3." This unusual title is derived from the fact that medical progress has helped raise our average life expectancy at birth from 20 years in ancient time to the present 69.3 today.

Narrated by Alistair Cooke, the documentary is a black-and-white 16 millimeter film, and runs 14 minutes. Requests for free bookings should be sent to: Institute of Visual Communications at 40 East 49th Street, New York 17, N. Y.

William G. Kuhn, Jr., M.D.

New Brunswick

Sprains and Strains of the Knee Joint*

Strains and sprains are too often thought of as "minor" matters to be handled casually. Actually they can lead to serious disability unless vigorously studied and treated. Dr. Kuhn here suggests a practical modus operandi.

What is a sprain? What is a strain? A *sprain* has variously been described as a partial avulsion of ligaments; as a stretching of ligaments; or, a complete tear of ligaments about a joint due to a twisting or wrenching motion of the bones or joints.

A *strain* involves a complete or incomplete tear of muscles or their tendons due to a contraction of the muscle or tendon.

This discussion is directed to the narrow but deep channel between the obviously completely torn tendons and muscles, on one hand, and the obviously completely avulsed or ruptured ligaments on the other hand.

We are in agreement that early surgical repair of the more obvious complete severe sprains and strains is imperative. Nor can it be denied that a long convalescence and rehabilitation period result in a knee upon which surgery has been accomplished too early and without proper preparation of the extensor apparatus. Arthrotomy too enthusiastically undertaken without using discerning diagnostic accuracy pre-operatively, also prolongs the patient's final recovery.

However, the narrow and yet so deep channel between these two extremes, challenges our diagnostic acumen, our persuasiveness with patients, and our patience with patients.

We tend to see many more sprains and strains of the knee joint that can be classified as "incomplete" or "partial." These fall into the deep channel now under discussion more readily than the more dramatic "complete" injuries.

Diagnostic accuracy is paramount. In those cases seen early (from minutes to twenty-four hours after onset of trauma) certain advantages are naturally present. There is less edema of associated structures. Hematoma, if present, is readily identified and differentiated from effusion. The patient is more clearly able to recall the mode of injury and able to localize areas of pain more accurately. Hence, the "golden moments" of accuracy are at hand if we use them. When one has ruled out associated complete ruptures and tears of ligaments and menisci, reassessment of the patient in twenty-four hours is essential. If one is still certain he does not have a situation of surgical urgency, the first phase of treatment which one has already begun is continued.

That first phase is the control of hemorrhage and associated swelling. It should be started as soon as possible. Usually, application of ice water or ice packs plus supportive compression of the joint by bandaging over sponge rubber or felt is done as soon as the examination is completed. If examination has been delayed the bandaging and application of cold can be instituted by aides such as, interns, nurses, athletic trainers or rescue squad men.

*Presented May 17, 1960 at the Annual Meeting of The Medical Society of New Jersey.

After 24 to 48 hours of elevation and rest (with the exception of bathroom privileges on crutches) quadriceps setting is begun.

Immobilization is discontinued as soon as pain permits. Rarely is a cast or cylinder applied for over four to seven days. Moist heat after the first 24 hours will aid in localizing the hyperemic effect and should be used intermittently only two or three times a day for a ten or fifteen minute period each time. Continuous application of heat should be avoided.

QUADRICEPS setting exercises accomplish three purposes. One result is the immediate physiologic action of aiding in the repair of damaged tissues by increasing blood flow and volume to the area and thereby, aiding in hematoma absorption and subsequent healing by proliferation of fibroblasts. Quadriceps setting prevents the onset of atrophy of the main extensor apparatus to the knee joint. This atrophy can begin demonstrably within three days after an injury. Every effort to head it off should be made. The exercise is an additional aid to diagnosis and is an "ace in the hole" in the event a first diagnostic impression was not accurate. If a diagnosis of the incomplete or minor tear or sprain is accurate, the exercises will promote an early complete cure. If the diagnosis was in error it has prepared the patient perfectly for the surgery that may follow. In fact it may have allowed a more accurate differential diagnosis in cases in which combined ligamentous and cartilaginous injuries have occurred.

The few days' delay in those cases that are clearly complete tears requiring immediate surgery is more than compensated by the fact that the diagnosis is now accurate and, therefore, the surgical approach and procedure is more definitive.

Another important factor is that the patient has already made a good start in establishing the rhythm of exercises pre-operatively. It is difficult to teach a patient this exercise immediately postoperatively if it has not been well ingrained in his cerebral cortex pre-operatively. If this has not been accomplished pre-operatively, the reflex refusal of the patient's will to overcome his pain may mean many days' or weeks' delay in regaining use of the extensor mechanism. This, of course, leads to further disuse atrophy, persistent swelling, stiffness and pain and, thereby, prolonged convalescence.

Teaching quadriceps setting exercises will challenge your persuasive ability. He is in pain and you must convince him not only of the urgency and necessity of the exercises but also impress him with the most definite fact: that it *can* be accomplished in spite of his obvious pain.

The instructions are given with both knees extended and legs supported by a table or bed. Heat and/or other modalities may be used, but are not essential. The patient is taught first how to contract the quadriceps of the normal extremity. He holds the contraction three to four full seconds with maximum effort. He then relaxes for a like period of three to four seconds and then repeats the contractions. Then the exercise is done simultaneously with the affected limb. Usually a patient in acute pain will be able to make five or ten contractions successively and then be able to repeat the effort hourly thereafter during that day.

The following day he can increase the repetitions of maximum contraction held for three to four seconds, for twenty to thirty times every hour. This is followed on the third day by lifting the foot and heel from the bed or table surface with the knee extended and holding the contraction again for a three to four second period as before.

AS SOON as sufficient progress has been made (usually within three to seven days) the patient may begin the phase of progressive resistance or quadriceps drill.

Here the maximum amount of weight the patient can lift is attached to the shoe or boot. This amount is then divided in half and the quotient is used for the amount of weight in these exercises. The progressive resistance exercise is done once or occasionally, twice a day using one-half maximal effort weight. The knee with one half maximum weight attached

to the foot or ankle is completely extended and held for three or four seconds and then allowed to return to the flexed position and a rest of three to four seconds follows. The effort is repeated only ten times. Every five to seven days the maximum load is re-determined and the weight for the exercise is recalculated accordingly.

During the acute stages weight-bearing is limited to partial weight-bearing with the aid of crutches and at first is limited only to bathroom privileges. As progress is made and the patient begun on progressive resistance exercises, weight-bearing can become progressively more complete.

This program as outlined lends itself to handling the far more common "middle of the road" type sprains and strains. It lends itself further by avoidance of the too early surgical intervention in those cases classified as "exploratory." Too frequently, the exploratory arthrotomy really means meniscectomy. In fact, most surgical approaches necessitate either severing a portion of the coronary ligaments of the menisci or the anterior borders of the collateral ligaments and thereby predestine the removal of the meniscus. This commits the knee to a prolonged postoperative convalescence if the extensor mechanism has not been properly prepared and the patient well indoctrinated. If error in original judgment is made (in which at first a course of conservative management was decided upon and as one's diagnosis becomes more accurate and surgical repair has become necessary) this patient will have then been well prepared for surgery before the hematoma becomes organized, before the tissues have become friable and the ligaments covered with granulation tissue, making them indistinguishable from surrounding connective tissue.

251 Powers Street

Industrial Medicine Fellowships

The University of Cincinnati offers graduate fellowships in Industrial Medicine. These provide professional training for doctors who have completed at least one year of internship.

The three-year program (leading to the degree of Doctor of Industrial Medicine) satisfies requirements for the American Board of Preventive Medicine. Two years are devoted to intensive academic and clinical study in industrial medicine. A third year is spent in residency in an industrial medical department or in some comparable organization.

Stipends for the first two years vary from $3,000 to $4,000 depending upon marital status. In the final or residency year the Fellow is compensated by the organization in which he is completing his training.

Two other programs of study are available. A one-year course is offered to applicants who wish to become candidates for the degree of Master of Science. And a three-year academic program, leading to the degree of Doctor of Science, is available to applicants who wish to pursue careers in teaching and research. Fellowship stipends are available to candidates in these programs also.

Requests for additional information should be addressed to:

INSTITUTE OF INDUSTRIAL HEALTH
College of Medicine
Eden and Bethesda Avenues
Cincinnati 19, Ohio

George W. Irmisch, M.D.

Trenton

Renal Injury*

A case of renal damage without any history of injury is here presented. Dr. Irmisch also discusses problems of management.

Renal injuries are common in our present mechanized age, as the accident rate continues to climb. In producing kidney injury, the commonest types of forces are penetrating wounds, like those which result from stabbing or bullet wounds. Also common are kidney injuries that result from a direct force being applied to the loin anteriorly or posteriorly, such as we see in automobile accidents and football injuries; and falls resulting in injuries to the lumbar region such as in skiing and tobogganing mishaps.

Kimbrough[1] in 1946, reported that 24 per cent of penetrating wounds of the abdomen and kidneys required nephrectomy. He emphasized the seriousness of associated wounds of the chest and abdominal viscera. Blast injuries to the kidneys occurred during recent wars when a nearby shell or bomb would explode. These patients frequently suffer from oliguria or anuria but seldom required surgery.

Indirect force producing laceration of the kidney, was described by Dodson[2] in 1944, in a patient who injured his kidney lifting a heavy box; and Keyes[3] in 1936, described a laceration of the kidney in a patient who was swinging at a golf ball and missed. In other cases in the literature, there were lacerations of kidneys produced by lesser degrees of exertion. These kidneys were usually pathological to begin with and compression of the kidney as the result of muscular effort was sufficient to produce a rupture.

The symptoms of renal injuries are primarily shock, pain, hematuria and a mass in the loin.

Patients presenting these symptoms may be divided into two groups. The first or smaller group includes those patients who are presented in shock, with rapid pulse, restlessness, pain, abdominal spasm and a large fluctuating mass in the flank. They rarely respond to conservative management. Usually surgery must be done immediately.

The larger group of patients is usually seen hours after they have had a laceration of the kidney. The urine is grossly bloody and there is some discomfort in the flank. As they are not in shock, there is adequate time for examination and evaluation. It has been stated, that the diagnosis of injury to the kidney is rarely difficult, but the determination of the extent of the injury and of the choice of treatment requires careful observation and the use of every method of examination.

The second and larger group provides adequate time for blood studies, urine analysis and x-ray examination. This includes an intravenous urogram and subsequent cystoscopy and

*Read May 18, 1960, Section on Urology, Annual Meeting, The Medical Society of New Jersey.

1. Kimbrough, Alan: Archives of British Military Urology, 13:134 (January 1946).

2. Dodson, Lewis: Urologic Record of Patagonia, 4:456 (October 1944).

3. Keyes, B. W.: Kenosha County Medical Society Bulletin, 12:88 (October 1936).

retrograde pyelogram on the affected side. Blood pressure and pulse are measured at hourly intervals. After all of this information has been obtained, the decision may be reached as to whether surgery is indicated.

CASE REPORT

Two days prior to hospital admission, a 59-year old man complained of pain in the left flank which radiated around the front of the abdomen, producing nausea and vomiting. The pain became so severe that a physician was summoned and a hypodermic given. Twenty-four hours later the pain was less, but still present. The patient complained of moderate distress, frequency of urination, and dysuria. There was no previous history of a similar attack.

On admission, he looked "perfectly well." Blood pressure was 148/80. Palpable vessels were easily compressible. There was normal cardiac tone, rate and rhythm. Urine was yellow, specific gravity was 1.020; an occasional leucocyte was seen microscopically, but otherwise urine was "negative." Sedimentation rate was 33 millimeters per hour. Blood urea nitrogen was 18 milligrams per cent. Erythrocyte count was 3,200,000; hemoglobin 61 per cent or 9.5 Grams.

Figure 1 shows the x-ray.

An intravenous urogram was done. On the preliminary film the left kidney shadow was not well outlined. There was no direct evidence of a calculus, but he did have a large diffuse soft tissue shadow extending down to the iliac crest. Following the intravenous injection of contrast media there was prompt excretion bilaterally. On the right side, the calyceal system appeared normal. The right ureter was normal in caliber. The left calyceal system was outlined. It was smaller than on the opposite side. Because of this distortion, a retrograde pyelogram was performed. (Figure 2) This was described as being "well within normal limits." The anemia was corrected by transfusion. Bleeding and coagulation time were normal. Platelet count was 246,000. Barium enema revealed the entire large bowel distended normally down to the cecum in a retrograde way. There was no alteration of the mucosa nor was there any indication of intrinsic neoplasm. Lateral films of the abdomen failed to reveal any evidence of displacement of the colon.

Following the evacuation of all residual barium, a pre-sacral air injection was accomplished. (Figure 3)

Following pre-sacral air injection (1000 cubic centimeters) films of the upper abdomen were obtained at 30 minutes, one hour, two hours and 24 hours. The air was found to be in the retroperitoneal space beneath the diaphragm on the right side. The psoas muscle, kidney and adrenal glands were well outlined and presented a normal appearance. No air was seen to collect in the left retroperitoneal space, but once again, we saw the large diffuse soft tissue shadow extending down to the level of the iliac crest.

Surgical exploration was then planned.

A primary left dorsal-lumbar incision was carried through the structures of the abdominal wall to the peri-renal tissues. The peri-renal fat was completely organized and full of old clots. An extensive hematoma was seen extending from be-

Figure 1A

Figure 1B

Figure 2

Figure 3

neath the diaphragm well down over the iliac vessel. In the center of this mass was a kidney, essentially normal with the exception of a "dimple" at its lower pole. This was the site of a previous renal cyst, which had ruptured and bled. It was biopsied for microscopic diagnosis and the mass of clots with some of the peri-renal fat was evacuated. Drainage was instituted and the wound was closed in the usual fashion.

Microscopic examination of the tissue revealed a cyst of the kidney associated with a hemorrhagic area of the capsule. This hemorrhage extended into the parenchyma of the kidney. Pathologic diagnosis was, "Cyst of the kidney associated with capsular hemorrhage."

SUMMARY

THE diagnosis of injury to the kidney is rarely difficult. A case is reported which is of particular interest since there was no history of injury. The patient was a janitor in a local school. He had no knowledge of injuring himself and consequently, presented the picture of renal colic, as is typically seen when a patient is passing a urinary calculus. However obscure the diagnosis may be, this case further illustrates the importance of surgery when there is x-ray evidence of extravasation of urine or blood in the peri-renal tissue. A flank incision was utilized since there was no clinical or roentgenographic evidence of intra-peritoneal injury.

A massive hemorrhage which descended from the diaphragm to the iliac vessels facilitated surgical delivery of the kidney. Inspection of the kidney was relatively easy and adequate peri-renal drainage facilitated the successful conclusion of this case.

740 West State Street

R. A. Vlatten, M.D.

Newark

Promethazine-Meperidine-Scopolamine Pre-anesthetic Medication in Pediatric Patients

Children may need pre-anesthetic medication more than adults; yet are usually intolerant of the traditional narcotics. Dr. Vlatten here reports good results with a non-narcotic premedication.

Pre-anesthetic medication is an essential part of good pediatric anesthesia. Good judgment is needed to determine the amount of medication which will maintain the balance between adequate pre-operative sedation and over-sedation. The desired effect is often difficult to obtain in pediatric anesthesia since adverse side effects from narcotics are frequently pronounced, even when small doses are used. These pharmacologic by-effects lead to inadequate pre-anesthetic medication in children, and tend to suggest that in these patients, narcotic agents are not justified.

A reduced pre-anesthetic medication schedule results in a hyperexcited child who has to be forced to the operating room, held on the operating table by the nurses, and strapped with an ether mask by physical force. An experience of this kind must leave a lasting traumatic effect on the child. (Anyone who has seen a child on the second or third trip to the operating room will not readily or easily forget the expression of fear on the child's face and the resulting struggle which occurs only too frequently.)

This study was designed to evaluate the technic of pre-anesthetic medication for pediatric patients introduced by Sadove* (promethazine-meperidine-scopolamine). The technic was designed to improve the frequently unsatisfactory results obtained with the use of morphine-atropine pre-anesthetic medication in children.

PROCEDURE

Two groups of 100 patients each were included in this study. Ages ranged from 8 days to 16 years. Median age for Group I was 2 years; for Group II it was 3 years. Of the 200 patients, 98 were 2 years of age or younger, and 116 had received anesthesia at least once before.

The patients in Group I received promethazine (0.5 milligrams per pound) intramuscularly from 60 to 90 minutes before induction of anesthesia; meperidine in the same dosage intramuscularly from 30 to 60 minutes before induction; and scopolamine intramuscularly according to body weight—from 0.1 to 0.43 milligrams (1/650 to 1/150 grains).

The children frequently were awake hours before the scheduled operating time and before the administration of the pre-anesthetic medication. To sedate the children during these hours and, thereby, to improve the effect of the promethazine-meperidine-scopolamine pre-anesthetic medication, the patients

Note: The promethazine used in this study was supplied by Wyeth Laboratories (Philadelphia) as Phenergan®.

*Sadove, M. S. and Frye, T. J.: Two Papers in the J.A.M.A., 164:1729 (Aug. 1957) and the Preliminary Paper, J.A.M.A., 162:712 (Oct. 1956).

in Group II received additional promethazine (25 milligrams) in suppository form at least 2 hours before the procedure. Children under 25 pounds were given 12.5 milligram suppositories.

The types of anesthesia administered varied considerably; however, urathane-ether; cyclopropane; or sodium pentothal was used for induction and was maintained with ether (open drop); nitrous oxide, oxygen, ether; cyclopropane, oxygen, ether; or with a local anesthetic. In 126 patients, the anesthetic was administered endotracheally.

The operations included both minor and major surgical procedures such as appendectomy, craniotomy, and herniotomy.

Sedation was considered *very good* when the child was asleep at the time of transfer to surgery but could be awakened easily when necessary. Sedation was considered *good* when the child was awake but quiet and cooperative; *fair* when the patient was alert but could be controlled without physical force; and *poor* when restraint had to be used before induction could be carried out.

Induction of anesthesia was considered *very good* when the transfer from the stage of induction anesthesia through the excitement stage could be accomplished without struggle; *good* when initial resistance was present but the excitement stage was non-violent and of short duration; *fair* when there was considerable initial resistance and a pronounced excitement stage; and *poor* when there was extreme resistance to anesthesia and the excitement stage was violent.

Tracheobronchial secretion was designated as *absent, slight, moderate,* or *pronounced.*

RESULTS AND DISCUSSION

RESULTS obtained with the promethazine-meperidine-scopolamine for pre-anesthetic medication were very satisfactory. The sedation produced by the pre-anesthetic medication was either *very good* (35) or *good* (51) in 86 of the 100 patients in Group I. It was *fair* in 13 and *poor* in 1. In 72 children in Group I, induction was *very good* (28) or *good* (44); in 25 it was *fair,* and in 3 it was *poor.* Tracheobronchial secretion was *absent* (83) or *slight* (12) in 95 of the 100 patients in this group. It was *moderate* in 4, and *pronounced* in 1.

The patients in Group II either slept or were well sedated during the hours before being taken to surgery. The total number of children in Group II in whom the sedative response to the pre-anesthetic medication was *very good* or *good,* was the same as that for Group I (86 of 100 patients), but a definite percentage shift toward the better category was obvious (*very good*—69, *good*—17 for Group II as compared to *very good*—35, *good*—51 for Group I). The sedative response was *fair* in 12 and *poor* in 2 in Group II. Induction was *very good* (59) or *good* (31) in 90 children in Group II; *fair* in 9, and *poor* in 1. During induction, the children in Group II reacted considerably better than did the children in Group I (90 *vs.* 72 in the two acceptable categories). Endotracheal secretion was *absent* in 95 of the 100 patients in Group II, *slight* in 1, and *moderate* in 4.

There was no evidence of side effects in either group. Most of the patients did not remember anything concerning their experiences immediately before being taken to surgery or during the period of induction. The administration of promethazine suppositories eliminated the necessity of using barbiturates prior to the promethazine-meperidine-scopolamine pre-anesthetic medication.

CONCLUSIONS

1. In this study, the use of promethazine-meperidine-scopolamine for pre-anesthetic medication of pediatric patients proved to be very satisfactory. The effect can be improved with safety by giving promethazine, in suppository form, as an early morning sedative. The ad-

ministration of promethazine suppositories is practical and effective in eliminating the necessity of additional barbiturate prior to the pre-anesthetic medication proper.

2. The availability of the promethazine-meperidine-scopolamine combination has made pediatric anesthesia a less traumatic experience for these young patients. Retrograde amnesia after recovery from anesthesia was a welcome addition to the gratifying pre-operative sedation. Induction of anesthesia was made easier and tracheobronchial dryness during administration of anesthesia was generally present. No side effects from the medication were noted.

346 Roseville Avenue

The Myth of Regularity

At least 100 million Americans have become addicted to unnatural elimination aids because of unfounded worry over "regularity," according to *Today's Health* magazine. In the October 1960 issue, Charles W. Hook, M.D., Augusta, Ga., said:

"Old-fashioned habits, half-truths, and incorrect beliefs, and today's advertising have brainwashed the American public to accept the idea that a daily bowel movement is a necessity for everyone. Actually, nothing could be further from the truth! The idea of regularity has been swept down the ages on a tide of patent medicines.

"While the patent medicine men have had their field day selling laxatives and purgatives, the chiropractors, naturopaths, and food faddists have found a new wealth in the American worry over 'regularity,'" he said. Last year, Americans spent more than $148 million for laxatives and elimination aids.

Genuine constipation is generally caused by overactivity of the digestive tract. Anxieties often cause the bowel to move too fast and go into spasm, causing constipation. If the bowel moves too fast but does not go into a spasm, diarrhea usually results.

Real constipation (hard, dry bowel movements) should be brought to the attention of the physician.

Dr. Hook warned against the dangers of self-medication, saying that long use of elimination aids makes the bowel dependent on such aids. Some doctors believe up to 90 per cent of their patients had become addicted to such aids and were using them to extremes.

The public should be advised "to leave their digestive and elimination system alone."

The Nephrotic Syndrome

R. G. Mitchell reports in the April 16 (1960) *Lancet* that five children with the nephrotic syndrome who had not responded to hormone therapy were treated with large doses of cortisone given intermittently for long periods. All the children were girls ranging in age from four and half to twelve and a half years, and all had severe edema, hypoalbuminemia and proteinuria. Treatment was started with 20 mg. of corticotropin intramuscularly twice daily for 14 days. It resulted in satisfactory diuresis and disappearance of edema in all. Five days after the course of corticotropin was completed, treatment with cortisone acetate was begun by giving 100 mg. by mouth every six hours for three consecutive days, the total amount being 1200 mg. After four days without hormone treatment this three-day course was repeated for 20 weeks in the first three patients and for 52 weeks in the later treatment of all the patients. One tablet of penicillin G (200,000 units) was given twice daily and is being continued in all except one patient. This treatment enabled all the children to resume normal activities. Three have been in complete remission for 12 to 30 months since treatment with cortisone was stopped, but two relapsed after maintenance treatment was withdrawn. The results of treatment in this small series suggest that intermittent high-dosage steroid therapy is worthy of trial in every patient with the nephrotic syndrome who has not responded to standard hormone therapy. Although cortisone is satisfactory, prednisolone in equivalent dosage would probably be preferable in the future.

G. Barton Barlow, M.D.

Englewood

Prolonged Treatment of Hypertension with Rauwolfia Serpentina

Apparently it's really true what they say about the rauwolfia drugs: they do have a long-term hypotensive effect. Here, 90 per cent of the patients showed significant fall in blood pressure.

The basic aim of any schedule of treatment of the hypertensive patient is to prevent the development or extension of the vascular changes associated with chronically high levels of arterial pressure, which could lead to early death. Medical management of the hypertensive patient is thus directed towards a gradual lowering of the blood pressure to normal or near normal levels and the maintaining of those levels indefinitely. Any proposed treatment must be considered in the light of its safety when continued for many months, or even years.

The array of drugs [1,2,3,4] available today that will lower blood pressure creates a problem for the physician who must select the drug or combination of drugs which will provide optimal therapy for his hypertensive patients. Wilkins [5a] recently, and properly, urged conservatism as more effective antihypertensive drugs become available. He has recommended one of the rauwolfia preparations as the inital antihypertensive agent with other more potent drugs added subsequently, as required.

Since early in 1954, I have routinely used a preparation of whole root† Rauwolfia serpentina in patients with hypertension encountered in private practice. For most of these patients, this whole root of Rauwolfia serpentina was the only antihypertensive agent prescribed; in some cases, however, the blood pressure response to whole root Rauwolfia serpentina was inadequate, and one of the benzothiadiazine oral diuretic drugs was added after these agents had become available. A considerable number of patients have now been treated continuously with whole root Rauwolfia serpentina for several years, some for as long as five years without interruption. During this time whole root Rauwolfia serpentina has proved to be a highly satisfactory antihypertensive agent. Used as the sole antihypertensive drug, this has maintained satisfactory control of blood pressure levels and has promoted clinical improvement in a high proportion of the treated patients. In 17 of the 71 patients, response to whole root Rauwolfia serpentina was inadequate. In this group, diuretic drugs

†The brand of Rauwolfia serpentina used in this study was Raudixin®, produced by E. R. Squibb and Sons.

1. Schroeder, H. A.: Journal of Chronic Diseases, 1:497 (1955).

2. Wilkins, R. W.: Journal of Chronic Diseases, 1:563 (1955). *Also see* paper by same author, New England Journal of Medicine, 257:1026 (1957), *and also* by Wilkins, Annals of Internal Medicine, 50:1 (1959).

3. Gibbons, J. E. and others: Journal of the American Medical Association, 162:92 (1956).

4. Finnerty, F. A.: New York State Journal of Medicine, 57:2957 (1957).

5a. Wilkins, R. W.: Journal of the American Medical Association, 167:801 (1958).

were added to the schedule with significant declines in blood pressure levels accompanied by an increased sense of well-being. While some patients could not tolerate whole root Rauwolfia serpentina, the majority showed no unwanted reactions to the drug. The purpose of this communication is briefly to recount the experience of the author with whole root Rauwolfia serpentina in the continued treatment of ambulant hypertensive patients for many months, or even years.

PATIENTS

A TOTAL of 71 hypertensive patients comprises this series. They ranged in age from 35 to 80 years. Forty-two of them (60 per cent) were female. Hypertension had been present for at least one year in every patient, more generally for longer, and in some for as long as twenty years. (See Table 1). Pretreatment blood pressure levels varied from 170/90 to 240/120 with an average for the series of 207/108. A number of the patients had received previous antihypertensive treatment with variable success.

Complete physical examinations, including upright and prone blood pressure readings in both arms, were performed before and after treatment. The patients were also seen from time to time during their visits to the office throughout the period covered by this study. Particular care was observed to detect the appearance of any unwanted reactions to the drug.

MEDICATION

A PREPARATION of whole root Rauwolfia serpentina† was the sole Rauwolfia serpentina derivative used in the studies here reported. It was administered as tablets containing 50 or 100 milligrams of the drug in doses of from 50 to 400 milligrams a day. Initial doses varied from 150 to 400 milligrams and these doses were reduced as soon as the condition of the patient warranted doing so. The whole root Rauwolfia serpentina† was the sole antihypertensive agent prescribed for 54 of the 71 patients; in the remaining 17 patients, chlorothiazide or hydrochlorothiazide was added to the regimen because the blood pressure response to the whole root Rauwolfia serpentina alone was unsatisfactory, or because further declines in the blood pressure levels were considered desirable in these patients.

Periods of therapy with whole root Rauwolfia serpentina varied as follows:

Period of Therapy	Number of Patients
25 to 60 months	28
12 to 24 months	28
under 12 months	15

RESULTS

TO FACILITATE evaluation of the results, the patients were divided into three clinical groups, according to the length of time they were treated and the medication they had received. Patients treated with whole root Rauwolfia serpentina for less than a year were placed in Group I; those treated with whole root Rauwolfia serpentina for a year or longer were considered to be in Group II; while the patients who had received one of the benzothiadiazine diuretic drugs in addition to whole root Rauwolfia serpentina constituted Group III.

In gauging results, a decline in mean blood pressure of at least 20 millimeters was considered *significant*. "Mean" blood pressure is the average between systolic and diastolic. *Normal* blood pressure is taken to mean 150/90 or less.

Results are summarized in Table 2. It is evident from this table that blood pressure declined significantly under therapy in 64 of the 71 patients; and that they reached normal levels in 25 of the 71 patients. Of the 64 patients who exhibited a significant reduction in blood pressure, 47 had received the whole root Rauwolfia serpentina alone (Groups I and II), while 17 had received whole root Rauwolfia serpentina plus a diuretic (Group III). Or, stated another way, in 47 patients treated with

TABLE 1.

DURATION OF HYPERTENSION

Duration in Years	Male	Female	Total	Per Cent Female	Age Range	Average Age
1 to 5	13	13	26	50	35 to 71	52
6 to 10	11	11	22	50	44 to 74	61
11 or more	5	18	23	60	44 to 80	66

TABLE 2.

RESPONSES TO RAUWOLFIA ALONE OR COMBINED WITH DIURETIC AGENT

Group*	Total No. of Patients	Daily Dosage Rauwolfia in Milligrams	Average Duration of Treatment (months)	Average Blood Pressure Before Therapy	Average Blood Pressure After Therapy	Number Becoming Normotensive	Number Showing Significant Reduction in B. P.
I	15	50 to 400	4.3	206/108	174/91	3	11
II	39	100 to 400	32.3	195/105	158/85	17	36
III	17	100 to 400	31.2	213/108	164/87	5	17
Totals	71					25	64

*Group I—Patients treated with whole root Rauwolfia serpentina as the sole antihypertensive agent for less than 1 year.

Group II—Patients treated with whole root Rauwolfia serpentina as the sole antihypertensive agent for from 1 to 5 years.

Group III—Patients treated with whole root Rauwolfia serpentina for from 1 to 5 years, with chlorothiazide or hydrochlorothiazide added to the regimen.

Note: B. P. of 150/90 or less is considered normotensive. Decline in mean B. P. of 20 or more is considered "significant." Mean blood pressure is the midpoint between the patient's systolic and diastolic readings.

whole root Rauwolfia serpentina alone (11 for less than a year and 36 for at least a year) and *in every one of the 17 patients given combined treatment,* with whole root Rauwolfia serpentina and a diuretic, the mean blood pressure was at least 20 millimeters lower after therapy than before. Of the 25 patients becoming normotensive, 3 had been treated with whole root Rauwolfia serpentina alone for less than a year; 17 for more than a year; and 5 had received combined therapy.

Good to excellent symptomatic response was observed in 45 of the 71 patients. In these patients, headache, dizziness, tinnitus, dyspnea, "nervousness," tension and fatigue were greatly relieved or entirely dispelled. In an additional 12 patients, the clinical improvement was considered to be only fair, as the relief of symptoms was less than "good." The whole root Rauwolfia serpentina preparation was withdrawn in the remaining 14 patients in the series because of the development and persistence of unwanted reactions despite adjustment in dosage. The response in these patients was classified as "poor," and treatment was considered to have failed because of the patient's intolerance to the medication.

The side reactions are shown in Table 3. *Forty-eight of the 71 patients* (68 per cent) *were entirely free from any reaction to whole root Rauwolfia serpentina throughout the entire period of treatment* covered by this report. Of these 48 patients without reactions, 29 were found in Group II and 15 in Group III, while only 4 came from Group I. The remaining 23 patients in the series, however, developed one or more unwanted reactions to whole root Rauwolfia serpentina, which included nasal stuffiness, loose stools, and mental depression (See Table 3). In 14 of the 23 patients, one or more of these symptoms persisted after adjustments in the dosage schedule of the whole root Rauwolfia serpentina to smaller doses. Because of the distress and dis-

TABLE 3.

UNWANTED REACTIONS TO THE RAUWOLFIA PREPARATION

Patients Reporting the Reaction		Patients from Whom Drug was Withdrawn	Duration of Therapy Before Withdrawal (weeks)
12	Nasal stuffiness	1	52
8	Loose stools	3	4 to 6
9	Emotional depression	8	1 to 25
3	Nightmares	2	8 to 10
1	Drowsiness	0	—
2	Weight gain	0	—
1	Dry throat	0	—
48	No untoward reaction	0	—

Note: Since some patients reported more than one untoward reaction, total exceeds 71

comfort they caused the patient, the preparation was finally discontinued. In nearly every case, this apparent intolerance to the whole root of Rauwolfia serpentina developed during early stages of treatment; and in only two of the 14 cases requiring withdrawal of medication was treatment continued beyond six months. The most frequent cause for discontinuance of the whole root of Rauwolfia serpentina was mental depression, usually associated with loose stools, nasal stuffiness, or nightmares, and this required withdrawal of the drug in 8 of the 14 cases.

COMMENT

THE results of this study indicate that whole root Rauwolfia serpentina is a very satisfactory antihypertensive agent which may be safely administered for many months, or even years, without interruption. Prior to treatment, most of the patients included in this study were suffering from a well entrenched, moderately severe form of hypertension. Administration of whole root Rauwolfia serpentina as the sole antihypertensive agent resulted in declines in blood pressure to significantly safer levels in almost every case. In 17 cases, the concomitant administration of a benzothiadiazine drug enhanced the hypotensive effect of the whole root Rauwolfia serpentina. This led to further declines in blood pressure to more satisfactory levels than had been achieved with the whole root Rauwolfia serpentina preparation alone. The favorable symptomatic response in the majority of patients is also noteworthy and is in accord with the experience of others[4] in this respect.[5] The development of mental depression in 8 patients and of other unfavorable effects in 6 others, requiring discontinuance of medication underlines the need for careful supervision of patients being treated with this drug. Should similar reactions occur, the drug should be withdrawn. Similar reactions[3] have been reported elsewhere.[6] The occurrence of these reactions in some patients, however, does not lessen the usefulness of whole root Rauwolfia serpentina in the patients who do respond well to its action without adverse effects.

A word of warning should be added concerning the hazard from hypotension during administration of anesthetic agents to patients who have been receiving Rauwolfia therapy. Significant hypotension and bradycardia have developed during anesthesia in hypertensive surgical patients on Rauwolfia serpentina preparations or derivatives. These reactions did not respond satisfactorily to vasopressor drugs such as phenylephrine, but were corrected by vagal blocking drugs such as atropine and scopolamine.[7] Furthermore, experimental studies have demonstrated that the prior administration of reserpine decreased the blood pressure response to certain vasopressor drugs.[8] In view of these findings, both clinical and experimental, it is believed advisable (as

5b. Wilkins, R. W.: American Journal of Medicine, 17:703 (1954).

6. Moyer, J. H. *et al.*: Archives of Internal Medicine, 96:530 (1955).

has been recommended[7]) that *all forms of Rauwolfia serpentina be discontinued in hypertensive patients receiving the drug, two weeks before elective surgery.* If emergency surgery be necessary for these patients, intravenous vagal blocking drugs should be used to prevent and to treat falls in blood pressure or slowing of the pulse developing during induction of anesthesia.

SUMMARY

A TOTAL of 71 patients with a history of hypertensive disease for from one to twenty years, has been treated continuously for varying periods up to 5 years, with a preparation of whole root Rauwolfia serpentina.† Daily doses ranged from 50 to 400 milligrams. Initial doses varied from 150 to 400 milligrams with adjustment to lower doses, depending on the responses of the patient. A benzothiadiazine diuretic drug (chlorothiazide or hydrochlorothiazide) was prescribed in addition to the whole root Rauwolfia serpentina for 17 of the 71 patients whose response to whole root Rauwolfia serpentina alone was inadequate. Blood pressure levels declined significantly (with a mean fall of 20 milligrams or more) in 64 of the 71 patients and reached normal levels (150/90 or less) in 25 patients. Good to excellent control of "hypertensive symptoms," such as headache, tinnitus, vertigo, nervousness and fatigue, was achieved in 45 of the 71 patients. Side effects developed in 23 patients and required discontinuance of the drug in 14 of the 23 cases.

CONCLUSION

ON THE basis of the results obtained in this study, it is concluded that whole root Rauwolfia serpentina is an effective antihypertensive agent, which may be safely administered for months or years without interruption. When whole root Rauwolfia serpentina is administered concomitantly with a diuretic agent, an enhanced hypotensive effect is observed with further declines in blood pressure. Patients treated with whole root Rauwolfia serpentina should be carefully followed, and if serious reactions are noted, the drug should be withdrawn. It would appear that a small proportion of patients will not tolerate the drug well.

---

7. Coakley, C. S. *et al.*: Journal of the American Medical Association, 161:1143 (1956).

8. Eger, E. I. and Hamilton, W. K.: Anesthesiology, 20:641 (1959).

157 Engle Street

Heparin Preferred

Writing in the *Journal of the Mt. Sinai Hospital* (New York City, 26:562, October 1959) W. A. Epstein reports that anticoagulants of the dicoumarin type are being increasingly used in thrombophlebitis and accompanying pulmonary embolism during pregnancy. This therapy is not altogether safe. Fetal death from hemorrhage has been reported.

In 3 cases, fetuses died *in utero* five weeks after the start of anticoagulant therapy with warfarin. The mothers' prothrombin time was controlled and never exceeded 35 seconds. They showed no evidence of hypofibrinogenemia. The fetuses were severely macerated. Autopsy did not establish the cause of death.

Since warfarin seems to have played at least a provocative role in these cases, the use of this type of drug in pregnancy should be avoided. Heparin treatment is safer at this period.

WILLIAM J. FARLEY, M.D.

Nutley

Role of the Team Physician in Prevention and Treatment of Athletic Injuries*

Here is a compact guide for the high school team physician—especially for the doctor who serves a football squad.

MOTIVES behind the acceptance of a high school team physician's job should be based on the desire to prevent and to care properly for injuries in this vulnerable age group. However, in my case I suspect it initially had to do with the fact that I had tried for years to get to our football games each fall and rarely got there. Now it is obligatory I attend each game.

A team physician is primarily concerned with the prevention of injuries through adequate preparation; and he is concerned with immediate treatment and follow-up care aimed toward the restoration of normal function. Perhaps not a duty, but equally as important an obligation, is an attempt to maintain in one's school and community a proper perspective regarding athletic competition for the young: a perspective balanced by a realization of emotional and psychologic needs as well as physical prowess.

ADMINISTRATIVE MEETING

PRIOR to each new season in the early fall it is of great value to arrange for a meeting with the Board of Education, the Athletic Association and coaching staff for the purpose of establishing definite policies concerning medical care. You must emphasize in no uncertain terms where you, as team physician, stand: that your primary duty and responsibility is to give to each boy the best medical attention possible. It must be made clear and understandable that such a policy without compromise protects not only the players and team but the coaching staff and school as well.

A number of well meaning community groups unfortunately bring unwholesome pressure to bear in an attempt to produce winning teams. These groups number among them "booster clubs," influential business interests, die-hard alumni athletes and over-zealous, unthinking parents.

The team physician is the sole authority concerning medical matters and is the only one qualified to make such decisions. If this is not entirely so, the physician must undertake the job of properly orienting and educating the school administration as well as the necessary elements in the community. Your immediate reaction to unreasonable attitudes in this regard is to resign; this action would help no one, certainly not the players who deserve a square deal. On the other hand, the physician must be prepared to discuss with an open mind

*On April 2, 1960, the Child Health Committee of The Medical Society sponsored a seminar on school athletic injuries. This was held at Seton Hall. Dr. Farley is Team Physician at the Nutley High School and this paper was part of the symposium.

and carry out honestly worth-while suggestions presented to him from any direction if they represent better over-all care.

MEDICAL RECORDS

A REVIEW of the candidate's history of past illness and injury should accompany the pre-season examination. School health records may also be examined and in some cases, the doctor should weigh the boy's scholastic ability and personality characteristics. The emotional caliber and development of the player, one soon discovers, will influence the satisfactory management of his injuries.

Complete examination is necessary to detect physical abnormalities. However, the number of failures is always very few. Border-line defects require consultation with family physicians and sometimes with parents. Special attention should be paid to the boy's physical habitus rather than weight. The slender long-limbed adolescent is usually more injury-prone and must be handled more carefully than his stocky but lighter classmate. The same may be said for those with poor muscle tone and condition. Physical fitness testing for such candidates can be a worthwhile preventive measure. A subsequent appraisal in a couple of weeks, with the prospect of being dropped from the squad without satisfactory improvement, will promote more diligent early season training.

An up-to-date file card of each boy with a summary of essential facts and injuries should be kept. Such data is also helpful in compiling annual reports and analyses. A student "medical assistant" has been of great aid in maintaining these records.

The job of "medical assistant" is filled by an interested student usually from the managerial staff and was instituted in our school a few years ago. He acts as a trainer and liaison between myself and the team especially when I am not present. He receives training in first aid and some physical therapy and becomes adept at simple protective strapping and dressings. He maintains an appreciated and recognized position on the squad.

CONDITIONING

VOLUNTARY summer time conditioning in preparation for football is engaged in by only a few. Most candidates start from scratch. They are in good health but in no shape for a strenuous "contact sport." Three or four weeks is very little time for pre-season preparation. The team physician, as much as possible, should get to early practice sessions in order to know what is going on during this period in which there is a higher degree of susceptibility to injury. A slow and gradual approach to high speed, full contact scrimmage is essential. In our experience, *over one-third of incapacitating injuries occur prior to the first game.*

Heat exhaustion is a real hazard during hot September days and the staff and players must be made aware of it. With full equipment, work-outs must be limited, or practice drills conducted without uniforms.

INSTRUCTION

EXPERT coaching in the basic fundamentals of football not only guarantees a fine performance; but more important, a safe one. It is necessary that the beginner learn the correct and safe way to block, tackle, hit a line, fall on a free ball, *et cetera.* Improper and unsafe technics increase the possibility of injury many-fold. Painstaking and frustrating attention to this fact, especially by the freshman and junior varsity coaches, will greatly safeguard the green player.

EQUIPMENT

THE school that does not provide the best available protective gear should not field a football team. To provide second-rate equipment (either because of ignorance, or worse yet, because of "cutting budgetary corners") is unjustifiable. It is almost as bad as the failure to obtain and adequately reimburse a good coach.

Practice gear must be as good as the more "flashy" game uniform. A proper fit, properly put on, is required. A poor fitting helmet may invite disaster. An over-sized shoe may sooner or later cause a sprain. Worn-out gear must be thrown away. So-called reconditioned equipment must be checked with care. The third-stringer can be hurt just as badly as the star quarterback for want of a proper uniform. He, too, deserves exactly the same consideration.

The practice field, as well as the main stadium, should be in good enough shape for safe play since it may be used five out of six days.

The team physician should make himself aware of the most reliable protective gear and in the developments of the most recent safeguards. Much information in this regard can be obtained from a visit to a local college athletic department. A day with its experienced team physician and trainers during the September training period is also of great assistance in keeping abreast of all types of the latest technics and therapy.

RAPPORT WITH COACHES

INCAPACITATING injuries, especially to key members of a squad, can make the difference between a good and bad season. No one is more aware of this than the coach. The team physician, therefore, becomes an important member of the team. His decisions may greatly influence the outcome on the field.

Fortunately, in most high schools, the high-powered "win at any cost" policy of past dictatorial coaching dynasties has been replaced by a plan of instruction taught by coaches who are well aware of the emotional, physical and educational needs of the maturing athlete. One cannot help but have the greatest respect and admiration for the good coach who is in turn stern slave-driver, sympathetic father confessor, and fond team-mate to his charges. His salary seldom can match the sweat, long hours and devotion needed to develop a satisfactory winning team. Not infrequently, the coach of a losing team may receive discouraging abuse from the community and often unwarranted criticism from his school board. It is only his genuine love of the game and the occasional thrill of developing an awkward boy into a splendid athlete and person, or a green squad into a smooth-operating machine that enable him to continue.

External pressure and desire to win ball games may sometimes cloud the judgment of a coach in handling an injured player. The team physician can be of great service to the coach and player by maintaining a firm and consistent position. His decisions, however, must be made with the utmost fairness and careful thought in order to merit the respect of the staff. A scientific demagogue is almost as bad as a tyrannical coach, and about as demoralizing to the team.

One must demonstrate and convince all concerned of the practical advantages of sound medical care, including adequate convalescence, in ultimately producing the maximum playing efficiency of the team. The boy who is given a sufficient lay-off to heal his knee 100 percent is worth more to his team than by allowing him to hobble with supportive strapping at 70 percent efficiency through each remaining game. More important, the possibility of future disability is greatly reduced. The high school athlete is still in a state of active physical growth and development and, in most cases, far from maturity. Both coach and physician have a serious obligation to each member of the team, including the most mature senior to protect him from injury that might curtail his athletic activities in college or his physical fitness throughout a life-time. Too often a deplorable attempt is made to treat a star fullback like a professional who is seriously earning a living for his family.

Emergency procedures should be made clear. Age-old quasi-medical treatments and training aids for the athlete should be reviewed, as some border on witchcraft. This includes commercial gadgets, devices and machines of unproved value. Recognized protective strapping and supportive bandaging, and physiotherapy based on sound therapeutic principles become the essential ingredients in the active care of the injured.

SESSIONS WITH THE SQUAD

You must, early in the season, give to the players some insight into the duties of your job as team physician with emphasis on the responsibilities one has to each boy, to his parents and to the school. Point out that each candidate must accept his share of the responsibility of getting into shape; that the player who is not in top condition lets his team-mates down and exposes himself to injury. The need for complete warm-up and full range of motion of all muscle groups and joints before play is stressed. It is emphasized that injuries are known to occur during a moment of incoordination and imbalance, of unprotected physical or psychologic let-down, or of disregard for proper and safe fundamentals of play.

The basic forces and mechanisms involved in injury are explained and graphically demonstrated by blackboard drawings. This includes a simple idea of functional anatomy, particularly of the muscles, tendons, ligaments and joints.

It is also worthwhile to present a run-down on last year's injuries. For example, in 1959 there were 78 incapacitating injuries on our varsity squad that kept the player out of uniform. In 36 of these, the boy was out for one week or more and in 15 cases for over two weeks. Sprains were seen most frequently, numbering 35 and the knee joint was involved in 17 of the total injuries.

The initial management of the more common injuries are outlined, such as cold application, compression, elevation and rest. Frequently, the first signs occur at home after practice and a boy will have sensibly begun the proper care before reporting the next day. Danger signals of more serious head, back and internal injury and the necessity of reporting immediately are emphasized. Good personal hygiene, skin care and diet are also mentioned. An understanding of what to expect and why helps the normally impatient young athlete to better tolerate necessary but timely inactivity. As with your relationship with the coaches, you must get across to them that (in spite of often strict attitudes) you are "always on their side."

Make an attempt to guide them to the real values of being a member of such an athletic organization. To most, lasting benefits and memories will come mainly from warm companionship and a feeling of "togetherness" in belonging to a fun-loving but well-disciplined unit. The won and lost statistics alone have no influence whatsoever on good character and personality development.

CONTACT WITH PARENTS

Parents must also be considered as part of the squad. Interested parents live through the emotional ups and downs of their son throughout the season. This is especially true of their injuries.

The parents must be made aware of the effect of their attitudes and actions. They must be made aware also of the excellent protection offered the boy in regard to facilities, equipment, coaching and medical care.

Our school athletic association has inaugurated a worthwhile "Parents' Night" during which all aspects of the coming season are freely discussed. These include most of my comments expressed above and below on the prevention and actual management of injuries. Such an evening can do much to alleviate undue anxiety and promote an understanding, cooperative parents' group.

DAILY SUPERVISION

Almost daily assessment of the day's injuries and the status of recovery of those on the injured list is necessary. It has been possible, even with a busy pediatric practice, to visit the team medical room at the end of practice. Such an arrangement

is also much more conventient for you and more advisable than to have the injured player limping into your office, unannounced, at all hours. The players learn to expect you and you can maintain control of their progress and limitation of activity. Examinations are quick and easy as they come from the shower room.

It is made clear that any boy or parent has the opportunity to confer and be treated by his own physician if desired. In some instances, this is recommended. However, a written or personal report of the boy's condition must then be obtained from the physician because it is the team physician who must finally decide if he is ready for play. Orthopedic consultation and other specialists' opinions are obtained whenever necessary. With experience, clinical acumen increases and as team physician, you are usually in the best possible position to evaluate an injury.

PRE-GAME CHECK-UP

PREPARATION for the Saturday afternoon gridiron "spectacular" includes supervision of special protective taping of the squad particularly the "glass-men"; and final examination and report to the head coach of the currently injured players. The occasion is often accompanied by much emotional tension directly proportioned to the number of first string players on the injured list and the importance of the game. Not a little of this drama rubs off on the conscientious team doctor who is trying to be objective and fair to a hard working team, coach and player.

You will be confronted with strong appeals in the form of a possible loss of a regional championship for the team or a college scholarship for the individual athlete. Such circumstances are never adequate justification for doing what is medically wrong. Compromises rarely help the player or the team. One finds the emotional trauma to the boy soon is dissipated and forgotten. A temporarily "broken heart" heals much more quickly than a badly torn medial collateral ligament of the knee. However, you must give individual consideration to each boy and each injury.

FIELD EXAMINATION AND PROCEDURES

IT IS wise to introduce yourself to the game officials and especially to the visiting team physician, advising him of available ambulance, stretcher and other emergency facilities. If playing away from home, make corresponding inquiries.

Certain boys on the field can be relied upon to detect an injured team-mate. They will keep an eye on a player about whom you might be worried. It is the job of the captain or quarterback, especially, to inform his coach or physician. A second blow may multiply the degree of injury many times or prove disastrous to a serious head or spinal injury.

Careful observation from the side-lines makes one better able to evaluate an injury. Best vantage point is at the line of scrimmage, moving with the flow of play. You must frequently forego the pleasure of following the ball to observe how a hard hit or "clipped" player gets to his feet or whether his teammate arises from the bottom of a rough pile-up. A boy may try to mask an injury to stay in the game. Brief running comments to coaches concerning the player's condition are often helpful and removal to the bench at least for an examination may be necessary. If a needed player is then found fit for play, the coach is also quicky notified.

It is not necessary or wise to run out immediately on the field with each injury. It is better to wait to be beckoned by a well-informed coach or official. An exception is a head injury with possible loss of consciousness for it is diagnostically and prognostically helpful to estimate the period of unconsciousness, amnesia and clearing of the sensorium. In head injuries, be conservative. Even for fleeting haziness, a boy is benched until perfectly clear. If more than momentary unconsciousness is noted, he must be considered as a potential concussion and removed from the rest of the game. A recent ruling that requires an injured player to be at least tem-

porarily removed from the game, is an excellent one.

Examination on the field should be complete as necessary without wasting time. Rarely is your bedside manner exhibited before such a large audience. Conditions are not ideal, especially when the patient wears a full suit of armor. Nevertheless, you learn deftly to loosen a lace here or remove a strap there to get to the site of injury. There is nothing more important going on in that stadium than the examination of this boy. Time is not then of the essence. Ten thousand spectators, a 200-piece band, two football teams and assorted visiting dignitaries can wait and they usually patiently do. A stretcher should be used at the slightest indication. A more complete team room examination may then be made. Hospitalization may be warranted for further observation and x-ray.

It is advisable for the doctor to get in touch with the injured boy's parents to reassure them and to give additional instructions. If hospitalization is recommended, their family physician is called in at the parents' request.

A thorough post-game survey is made for injuries and a report is given the coach with an inactive list for the days following. An accurate diagnosis and an outline of subsequent care is made as soon as possible but frequently an examination in 24 hours will give a better idea of the extent of injury.

CONCLUSION

THE interested team physician can do much to protect the high school athlete. He becomes an expert in this special field of accident prevention. Beyond this primary duty he plays a role in a worthwhile educational effort which, if properly orientated, is a wholesome and memorable part of student life. Its benefits are not confined soley to a limited and talented few. Competitive athletic teams should be organized, however, in more than just so-called "major" sports and should be well coordinated with an active intramural program designed to promote greater interest and physical fitness of the entire student body.

There is a growing movement for more safe and sane athletic programs for the young. Refresher courses, seminars and symposia (such as this excellent one organized by the Committee on Child Health of The Medical Society of New Jersey) are being held throughout the country. There is a need for more emphasis, below the college level. The high school team physician should make every opportunity to attend these meetings.

The monetary gain of the team physician does not compensate for the time and effort expended in doing a good job. Adequate return, however, is received through one's efforts in assuring the young athlete a "fair shake" and in a truly satisfying experience.

322 Chestnut Street

Intussusception

H. M. Heinisch, writing in *Munchener medizinische Wochenschrift* (101:1407, Aug. 4, 1959) points out that intestinal intussusception is usually accompanied by vomiting. This symptom is not specific. The chief early symptom is brief colic, recurring after irregular intervals in a child previously in good condition. The tumor caused by the invagination may be felt through the abdominal wall or by rectal examination. Blood is found on the examining finger and in the feces, but this is not an early symptom. Nearly all the cases are in babies under a year old and there is a slight preponderance of boys over girls (56:44). Unless the symptoms rapidly clear up, surgical treatment is indicated.

Trustees' Meeting: September 18, 1960

At the September 18, 1960 Board meeting, it was announced that Dr. Frank S. Forte of Newark had accepted appointment as our Medical Society liaison representative to Seton Hall Chapter of the Student American Medical Association.

CONFERENCE ON LEGISLATIVE ACTIVITIES

Dr. McCall and the Executive Officer attended the AMA Regional Conference on Legislative Activities in Hershey, Pa., on August 26 and 27, 1960.

Dr. Allman was one of the leading figures at this conference. In the course of the conference we were informed as to what had happened in conjunction with the Mills Bill (HR 12580) and what part the AMA had played in federal legislation affecting medical interest during the current Congress.

CONFERENCE ON THE CARE OF THE MEDICALLY INDIGENT

With the approval of the Chairman of the Board, Irving Klompus, M.D., and Nicholas E. Marchione, M.D., from the Council on Medical Services were appointed by the President to attend the AMA Conference on the Care of the Medically Indigent in New York City, on July 22, 1960. This was primarily an information-type meeting. An abstract of the proceedings will be forwarded to Dr. Klompus and Dr. Marchione.

DIABETES DETECTION DRIVE

John J. Torppey, M.D., of Newark, has accepted appointment as the official liaison representative of The Medical Society of New Jersey to the 1960 Diabetes Detection Drive.

CONFERENCE ON LONG-TERM ILLNESS

Dr. McCall designated Dr. David Eckstein to participate in a program to be presented under the auspices of the Division of Aging for persons engaged in the care of long-term ill patients in medical institutions, nursing homes, and homes for the aged.

PUBLIC HEARING ON BLUE CROSS

Drs. Bowers and McCall and Mr. Nevin were named as our representatives to the public hearing, September 20, before the Legislative Commission investigating Blue Cross.

PRE-PAYMENT DENTAL SERVICES

The New Jersey State Dental Society has sponsored S-72 which will permit a non-profit dental service corporation. The enabling legislation is similar to the Medical Services Corporation Act and the Hospital Service Corporation Act as they pertain to Blue Shield and Blue Cross. Support of the Medical Society on this legislation was requested by the Dental Society.

Dr. Blaisdell moved—seconded by Dr. Allman, and carried—that the Medical Society support S-72 provided that Medical-Surgical Plan offers no opposition to the proposed legislation. It was later learned that the Plan had no objection to S-72, and the Governor was notified of the Society's support of the bill and urged to sign the measure.

POSTGRADUATE PROGRAM

Merck Sharp & Dohme has grants-in-aid available to assist medical groups in putting on satisfactory medical programs. The firm will pay the program expenses and give an honorarium to speakers appearing on such programs. Descriptive folders are available for distribution to the county societies.

MSP PUBLIC RELATIONS COUNSEL

The Board of Trustees of Medical-Surgical Plan stressed complete compliance with the

joint operating agreement between Medical-Surgical Plan and Hospital Service Plan with special reference to the following excerpts therefrom:

> "Nothing . . . shall in any wise affect the separate identities of the parties . . . No representations or commitments whatsoever shall be made . . . by Hospital Service Plan for Medical Plan except as herein provided.
>
> "While this Agreement remains in force, the form and content of all applications, literature and written publicity in connection with Subscription Contracts of both Plans intended to be offered for enrollment thereunder solicited by Hospital Plan hereunder shall be issued only after approval by both parties.
>
> "Relationships with physicians and with subscribers and covered dependents regarding services rendered by physicians under Medical Plan Contracts shall be administered solely by Medical Plan. Relationships of Medical Plan with the general public shall be the joint responsibility of Medical Plan and Hospital Plan and shall be carried on through the facilities of the Public Relations Office of the Hospital Plan."

Dr. Allman moved—seconded by Dr. McCall, and carried—that the Board of Trustees request the Board of Trustees of Medical-Surgical Plan to further review the status of a separate Public Relations Counsel for Medical-Surgical Plan.

MSP APPORTIONMENT OF FEES

The MSP Board reaffirmed and continued the present policy, as set forth in the Schedule of Payments and General Provisions thereof, of apportioning Plan payment for a surgical procedure between the attending surgeon and another physician who assists in rendering concurrently the surgical services.

MSP PAYMENT TO DENTAL-ORAL SURGEONS

Upon the advice of Legal Counsel the Plan Board finds that the Plan cannot legally make payments to dentists under the present provisions of the Enabling Act. The Dental Society, however, has been notified of the action of the 1960 House of Delegates in approving direct payment to dental-oral surgeons by MSP. The Dental Society will be notified of the above reply from Medical-Surgical Plan.

Dr. Bowers expressed the opinion that the Society should support the dentists in their attempt to obtain MSP payment for work done by them in hospitals.

In the course of discussion, it was pointed out that the dentists themselves should take the initiative and request MSP to amend the Enabling Act, just as the chiropodists successfully pressed for an amendment to include payment for their services under MSP.

Dr. Bowers moved—seconded by Dr. Buchanan, and carried—that the matter be referred to the Medical-Dental Liaison Committee for consideration, and that the committee bring in a proposal.

PAID-UP POLICIES IN BLUE CROSS-BLUE SHIELD

Medical-Surgical Plan and Hospital Service Plan have completed a comprehensive study of the resolution adopted by the 1959 and 1960 Houses of Delegates in regard to the possibility of withholding funds from premium payments to provide paid-up Blue Cross and Blue Shield policies to subscribers on retirement. The study was a twofold project conducted independently by the Plans' Research and Statistical Department and the Consulting Actuary.

A summary of the reports and conclusions of the studies was submitted for the Board's information, the final paragraph of which stated:

> In view of the imperative necessity of building up adequate reserves at age 65 for the health-risks for the remainder of life, and of the reluctance of the State Department of Banking and Insurance to permit the accumulation of such reserves, the proposal to offer contracts or certificates paid up at age 65 must be regarded, at present, as academic and impracticable.

CONTINUING PR PROJECTS

Approval was unanimously given to the following continuing public relations projects for 1960-61, with the recommendation that they be approved by the Board:

(a) Publication and distribution of *Junior Health Hints* to the schools, *Health Hints* to the press, *Membership News Letter, Periodic Newsletter* to cooperating agencies.
(b) Preparation and publication of special news releases and publicity as required from time to time in furtherance of the Society's business and interests.
(c) Preparation and distribution of a membership service kit.
(d) Encouragement of indoctrination program under the sponsorship of the component societies.

(e) Continuance of consultative service in support of the public relations activities of component societies.
(f) Responsibility for the bestowal of the Golden Merit Award.
(g) Maintenance of press clipping service for the Society's public relations features, releases, and press notices.

In conjunction with these continuing projects, the council also recommended that:

(1) in connection with the annual meeting, the council have an exhibit of its releases and periodicals for the information of the membership;
(2) the *Junior Health Hints* be made available to public and school libraries of New Jersey for the reference of biology students;
(3) in connection with the Golden Merit Award, the bestowal ceremonies take place on the stage and not on the floor level.

These continuing projects were approved.

Dr. Bowers moved that the recommendation concerning the Golden Merit Award ceremonies be amended by adding "if feasible and be left to the discretion of the chairman of convention arrangements." This amendment was carried.

WOMAN'S AUXILIARY PROPOSAL

A proposal was received from Woman's Auxiliary for evaluation and recommendation by the Council on Public Relations:

> A public relations program from the medical viewpoint on care of the aged be presented in Trenton in October with representatives from state organizations being invited to be sponsored by The Medical Society of New Jersey.

The Council agreed that this proposal has merit; but because of the present status of legislation concerning the medical care of the aged, the Council did not feel that at this time it could best use its energies through fostering such a program as proposed.

Instead, the Council recommended that the proposal be referred to the attention of the New Jersey Joint Council to Improve the Health Care of the Aged, with the thought that the Joint Council perhaps would be willing to sponsor a program of this type to which the Auxiliary and the public could be invited.

METROPOLITAN BROADCASTING CORPORATION

Metropolitan Broadcasting Corporation is filing an application for a television channel, and proposes to schedule a number of local live telecasts in programs of general interest. It asked if the Medical Society "and/or members would assist in producing of programs in your field, if we should receive the television license."

The Council on Public Relations agreed that since it is all so tentative, the Medical Society should make no commitment. Since the station is not a New Jersey one and not well received over a wide area in New Jersey, it would not pay the Medical Society for the trouble and expense involved in the preparation of program materials.

PUBLIC RELATIONS ROUNDUP CONFERENCE

The Council on Public Relations considered the desirability of holding a public relations roundup conference to review what is being done in the significant areas of public relations by the county societies. Each county society would come prepared to report, for example, (1) on the operation of its emergency call system; (2) upon its relations with local representatives of press and radio; (3) on its procedures of indoctrination of new members; (4) and on any other program with which it is experimenting or with which it has had successful experience. By means of this review of what is being done at county level, perhaps the Council can achieve uniformity of procedures and the introduction of new undertakings. The proposed roundup conference could also give the Council a chance to review the points that should be emphasized to make the individual physician do his proper part in advancing medicine's public relations.

Council accepted this idea as a step that is indicated to vitalize and unify our public relations interests and activities throughout the Society, to evaluate what has been done and is being done, and to determine what further should be sought for and accomplished.

The Council therefore recommended unanimously that a Public Relations Roundup Conference be held on October 26, to which would be invited executive secretaries and chairmen of public relations committees from component societies as well as public relations representatives from the Auxiliary. This was approved by the Board.

CONFERENCE ON PHYSICIANS AND SCHOOLS

Upon motion by Dr. Bedrick—seconded by Dr. Jehl, and carried—the Board authorized

Dr. Robert E. Jennings, Chairman, Special Committee on Child Health, to attend the A.M.A. Conference on Physicians and Schools, March 9 to 11, 1961 in Chicago.

FUTURE PHYSICIANS CLUB

Dr. Kalb reported on a project which has been initiated in New Jersey by the Essex County Medical Society—"Future Physicians Club." The members of the club are high school students who "have an interest in the biologic sciences and exhibit good study habits." In promoting this project, the Essex County Medical Society is "attempting to recruit talented and dedicated students for medical careers." On recommendation of our Public Relations Council, the Board agreed that this Society should encourage all component societies to organize and operate "Future Physicians Clubs" within their county boundaries.

WHITE HOUSE CONFERENCE ON AGING

Dr. Blaisdell informed the Board that the New Jersey report to the White House Conference on the Aging is being prepared, and will be available October 15. He expressed his concern over the fact that the Society did not present a formal statement of its position at the Glassboro Conference. The Board then determined that the statement previously submitted to the House Ways and Means Committee be forwarded to Mrs. Hager, with the request that it be included in the forthcoming New Jersey report.

CONFERENCE ON MATERNAL AND CHILD CARE

Upon motion by Dr. Lloyd—seconded by Dr. Bedrick, and carried—the Board authorized Dr. John D. Preece, Chairman, Special Committee on Maternal and Infant Welfare, to attend the A.M.A. Regional Conference, October 9, in Boston.

A.M.A. CLINICAL MEETING

The following were authorized to attend the A.M.A. Clinical Meeting, November 28—December 1, 1960, in Washington: President, President-elect, Secretary, and Executive Officer. Dr. Elton W. Lance was named alternate delegate to attend the Clinical Meeting.

The Board named Dr. Joseph P. Donnelly as substitute alternate delegate to attend the meeting, in the event Dr. Lance cannot be present.

MEDICARE

The Board authorized the Chairman and Secretary to sign an amendment to the Medicare contract permitting a different method of payment for post-partum care, where such care is divided between two physicians, in and out of the hospital.

Dr. Ware recommended the Board authorize the Chairman and Secretary to sign Contract modification Number 61 as submitted. He reported that, with one exception, all changes are non-controversial.

Medical Service Administration has signed the agreement, despite its exception to one item which empowered the fiscal agent to assist the government in collecting money paid physicians for care of unauthorized persons.

Upon motion by Dr. Jehl—seconded by Dr. Bowers, and carried—the Board authorized the Chairman and Secretary to sign the modifications to Contract Number 61.

CONGRESS ON INDUSTRIAL HEALTH

The Board authorized Dr. Willis B. Mitchell, Chairman, Special Committee on Industrial Health, to attend the A.M.A. Congress on Industrial Health, October 10 to 12, at Charlotte, N. C.

MEDICAL STUDENT LOAN FUND

Dr. Lloyd reported that two eligible senior medical students, who had in previous years received financial assistance from the Medical Student Loan Fund, were unable to obtain loans for the current year. This was due to the fact that loans had been granted in an amount equal to the total available for disbursement before the applications were submitted by these two students.

The Board noted that the Fund could *not* be increased by a transfer from general society funds, because monies voted by the House of Delegates cannot be diverted. A suggestion was made that a recommendation could be forwarded to the House of Delegates to the effect that our contribution to A.M.E.F.

be limited until such time as the Medical Student Loan Fund reaches the desired goal of $100,000.

The Executive Officer suggested that the Woman's Auxiliary might be requested, as part of its program, to emphasize collection of funds for the Medical Student Loan Fund.

Upon motion by Dr. Buchanan—seconded by Dr. Bowers, and carried—the suggestions were approved.

Dr. Jehl moved—seconded by Dr. Bowers, and carried—that the component society secretaries be apprised of the increasing number of requests being made upon the Medical Student Loan Fund, and be urged to circularize their membership for contributions.

Dr. Jehl stated he would take it upon himself to see that the Passaic County Medical Society set up a memorial fund in honor of Joseph E. Mott, M.D.

Liability Insurance for State, County and Municipal Employees

Prepared at the request of the Council on Legislation by E. Powers Mincher, Legislative Analyst to the council, with the cooperation of Robert M. Backes, the Society's Legal Counsel. Presented here with the approval of the Board of Trustees for the information of our members.

Early in 1959 it was brought to the attention of the Board of Trustees that there is some likelihood that professional employees of state, county, and municipal governments might not be adequately protected in the event of suits for damages involving their actions as employees of government. Among the means suggested for the correction of this situation was the possibility of introducing legislation. The matter was referred by the Board of Trustees to the Council on Legislation for consideration.

At the time of presentation to the Council on Legislation of this problem as relating to malpractice insurance, insurance carriers were not issuing policies protecting municipal, county, or state employees in the event of litigation alleging malpractice by such employees in the performance of their duties for their respective governments. This problem was further complicated by the fact that protection of professional personnel employed by the various subdivisions of government in the performance of their duties did not appear to be established by decided cases or statute law.

Problems relating to protection of employee professional personnel in their performance of duties for government agencies were made known to the State Commissioner of Health, Roscoe P. Kandle, M.D., in July of 1959. The Commissioner described the problem in detail to the Governor's counsel and to the Attorney General and recommended that, if case decision could not be relied upon as authority for protection of such personnel, legislation be drafted and enacted for that purpose. The Commissioner also directed that negotiations be entered into for the purpose of inducing insurance carriers to issue policies protecting governmental employees in the performance of their duties.

Negotiations initiated by personnel of the State Department of Health have resulted in an offer by an insurance company to insure professional personnel of the State Department of Health—including physicians, nurses, and veterinarians—against malpractice suits.

There is little doubt that that company, and possibly other companies, would now be willing to offer similar contracts to personnel of other political subdivisions of government at county and municipal, as well as state, levels. Said offer was made in the spring of this year.

Subsequently, the Office of the Attorney General advised the Commissioner that the case of Bedrock v. Brewster, 31 N. J. 124 (1960) could be relied upon to protect professional personnel of state government against legal liability for acts performed by them in the course of their duties and responsibilities. The Department was advised in this regard to the effect that in the absence of fraud, malice, or willful negligence and when acts are done with honesty and in good faith, state employees rendering services that require the exercise of discretion or judgment are generally held not culpable for actions resulting in damage or injury. These basic principles of law as enunciated in the Bedrock v. Brewster case can be relied upon to support similar conclusions on behalf of county or municipal employees. In the absence of a commitment by the county or municipal government to de-

fend the professional employee, such employee would be obliged himself to assume the expense of the defense of any claim against him. Therefore—where the services of the Office of the Attorney General, or others, are not available in the event of litigation, the expense involved in defending actions is an item for consideration prior to a determination to rely upon case law in preference to insurance coverage.

In view of the above, it would appear that the problem of protection of professional personnel in the performance of their duties for any political subdivision—state, county, or municipal—can be resolved either by the obtaining of an appropriate contract of insurance or by reliance upon the case above referred to. In the State Department of Health, the position taken in the interest of effecting savings to the State was to rely upon the decision in the case of Bedrock v. Brewster and the services of the Office of the Attorney General in the event of possible litigation involving acts of professional employees of the State in the performance of their duties.

Obituaries • • •

DR. ALDO B. COULTAS

A long and useful medical life came to an end on October 14, 1960 with the death that day of Dr. Aldo Bliss Coultas at his home in Madison. Born in 1877, during the administration of President Rutherford Hayes, Dr. Coultas received his baccalaureate degree at DePaul University in Chicago in 1898 and his M.D. in 1902 at Columbia University's College of Physicians and Surgeons. This brought him east from his native state of Illinois—and here he stayed. Accepting an internship at Paterson General Hospital, he got to know—and like—our state. In 1904 he entered private practice in Madison, and there he served the people of Morris County for more than half a century. At first a general practitioner—and a rural family doctor in the honorable tradition—he became increasingly interested in surgery, and became a member (later consultant) of the surgical staff at All Souls Hospital in Morristown. A Fellow of the International College of Surgeons, Dr. Coultas was active in civic organizations, and served as president of the Madison Kiwanis Club and as a District Governor for the Kiwanis in New Jersey. He was active in the affairs of our Morris County Medical Society.

DR. F. LAWTON HINDLE

At the untimely age of 54, Dr. F. Lawton Hindle died of nephrosis at the Riverview Hospital in Red Bank on November 3, 1960. Born in New Brunswick, Dr. Hindle was graduated from Jefferson Medical College in 1937. After interning, he came to Monmouth County and served the people of that area since 1939. At first a general practitioner, he became increasingly interested in gynecology and obstetrics, and was affiliated with both the Monmouth Medical Center in Long Branch and the Riverview Hospital in Red Bank. At the latter institution he served in all grades on the obstetrical service, and at the time of his death was director of obstetrics there. He was active in the affairs of the Monmouth County Medical Society.

DR. LOUIS HUSS

Dr. Louis Huss of Union City died suddenly at his home on October 5, 1960 at the age of 50. Born in Hungary, Dr. Huss received his early education in that country and was graduated from the University of Rome in 1935 with an M.D. degree. He was affiliated with the North Hudson Hospital, Weehawken. Dr. Huss, a member of the Hudson County Medical Society, was a general practitioner.

DR. DONALD C. LYNCH

Mercer County medicine was shocked on November 6, 1960 with the death that day of Dr. Donald C. Lynch who was only 48 years old. A native of Trenton, he received his baccalaureate degree at Princeton in 1933 and his M.D. at Harvard in 1937. He returned to Trenton to intern at the Mercer Hospital and then entered private practice. For a short time he did general medicine, and at the time of his death had been, for some years, a chief on the medical service. Dr. Lynch was a director of the Trenton Boys' Club and a trustee of his church. He was elected in January 1960, secretary of the medical staff of the Mercer Hospital.

General Session

May 16, 1960

The General Session was convened at 3:45 p.m.

THE PRESIDENT: Ladies and Gentlemen: On behalf of The Medical Society of New Jersey, I welcome you here this afternoon. Our General Session will be divided into two portions, the first will be the inaugural address by our new President, Dr. Jesse McCall; and the second will be the symposium on the problems of the aged—in fact and fancy. It is now my pleasure to present to you my long-time friend, colleague and neighbor, our new President of The Medical Society of New Jersey—Dr. Jesse McCall.

(Standing ovation)

(President-Elect McCall then read his inaugural address—see page 452, August JOURNAL.)
(Applause)

THE PRESIDENT: Now you can see that The Medical Society of New Jersey has chosen wisely and that we will be in good hands for the coming year.

Dr. McCall, I wish you and your new administration well, and God bless you. (Applause)

Now we proceed to the second portion and that is a symposium on the problems of the aged—in fact and fancy. Let me now present another long-time friend and classmate—Dr. Ralph M. L. Buchanan, the new President-Elect of The Medical Society of New Jersey, who will moderate this panel. Dr. Buchanan. (Applause)

THE MODERATOR: As you know, the symposium this afternoon is listed on your program as The Problems of the Aged—in Fact and Fancy.

Three of the speakers on this panel need no introduction to most of you in the audience. The first one is our Executive Officer, Richard Nevin, who will cover the area of the human and social needs. Mr. Nevin. (Applause)

(Mr. Nevin then read his paper—see page 713, this issue)

THE MODERATOR: Thank you, Mr. Nevin. Now I give you Dr. Blaisdell, a member of the Board of Trustees, Chairman of the Council on Legislation, who will present it from the area of the physical needs. Dr. Blaisdell. (Applause)

(Dr. Blaisdell then read his paper—see page 715, this issue)

THE MODERATOR: Thank you, Dr. Blaisdell.

Our next speaker is from Baltimore. He is President of the American Health Insurance Corporation. I give you Mr. William Washburn. (Applause)

(Mr. Washburn then read his paper—see page 717, this issue)

THE MODERATOR: Thank you very much, Mr. Washburn.

We now come to our own Dave Eckstein from Trenton, New Jersey, who will cover The Balance That is Power—to Survive. Dr. Eckstein. (Applause)

(Dr. Eckstein then read his paper—see page 719, this issue)

THE MODERATOR: Thank you, Dr. Eckstein.

Are there any questions from the floor that you want to direct to any member of the panel?

DR. SHARP: Mr. Chairman, rarely have I heard such a complete analysis of this situation. I move the meeting adjourn.

THE MODERATOR: Thank you. If there is no objection, we will adjourn, with a rising vote of thanks to our panel.

(Standing ovation)

(The meeting was then adjourned at 5:10 p.m.)

The Problems of the Aged — in Fact and Fancy

IN THE AREA OF HUMAN AND SOCIAL NEED

Richard I. Nevin, Executive Officer, Trenton

Mr. Chairman, members of the panel, members of The Medical Society of New Jersey and its Woman's Auxiliary, ladies and gentlemen:

We are met here today, in this staid and tranquil hour, dispassionately to consider the state of the people of this nation who are sixty-five years of age or older, and to distinguish the real problems which confront them from the false problems attributed to them. It is my part in these deliberations to deal with their problems in the area of human and social need.

The most poignant and bitter problem confronting our people who are in the hours of life's sunset glow is the realization that they have, in themselves, come to be regarded as a problem. Under the conditions which obtain today, of them it cannot honestly be said "old age hath yet his honor and his toil." In the years of their lives which should be the years of fulfillment, at that interval of their lives in which they should, in serenity and peace, enjoy the fruits of their labor and their love, they find themselves without secure place in our hearts or in our homes—a lingering embarrassment to a fast-paced and selfish society that will not suffer them to be gainfully employed but, in a spurious spirit of loving care, insists upon retiring them to the rueful enjoyment of social penury, ostracism, and economic dependence upon self-righteous and mealy-mouthed public support.

Yet the poet sings:

> "Grow old along with me!
> The best is yet to be,
> The last of life, for which the first was made."

Humanly, his whole life through, the normal American man hungers for the affection and admiration of other human beings who are important to him. To attain this goal he seeks place and fulfillment as a person. He wants to be needed by others and wants others to need him. He wants to savor the sweet success of contributing to the general good by providing for himself and his dependents. He wants the sense of personal success that comes when by his own efforts and through his own strength he knows that he has made himself and his loved ones secure against the average vicissitudes of life.

If at the end of his life a man can see that he has striven and worked with profit and benefit to himself and those whom he loves and serves, he then awaits the close of life in contentment, security, and peace—of body and soul. For such a person life has been a test and a struggle, but he has passed the test, and he has won the struggle. For him, with deep delight, "The end crowns the work." He can look to the past with satisfaction, to the present with equanimity, and to the future without fear . . . In his heart the exultant cry "I have done my part here; the rest is in the hands of God! . . ." Unfortunately, few men so live—or in such happy spirit, prepare to die—today. Human needs are not thus being gratified in our country today except for a fortunate and diminishing few.

Socially—that is as a member of contemporary society—the normal American man needs to feel that he freely shares the responsibilities, rights, and privileges proper to all under the system which exists. He wants to be part of a social system—honestly conceived and honestly administered—which will give him equality of advantage and of opportunity, encouraging him to strive for and enjoy such benefits as he can fairly attain, but—in the event of his failure—providing for him, out of the abundance of others, sufficient for his basic needs. He needs and wants to be part of a society that is rooted in justice but never to the exclusion of compassion and charity. He needs and wants, in short, to be part of a society that is good, integrated, and cooperative. He knows that in such a society—and only in such a society—are peace and security possible.

Basic to the realization of the human and social goals of the citizen is the preservation for him of a status of freedom and independence. He must retain direction and control over the elements of his daily living, so that, electing the ends to be attained, he may employ the means necessary in his view for their attainment—provided, of course, that both ends and means of his choice are not in violation of the rights of other individuals or in conflict with the general good.

In this scheme of things, it is the prime duty of government to maintain such a climate for living as will enable the individual citizen —with no restrictions other than his ability or industry imposes—to select goals for himself and his family and—without handicap—to press on to their attainment.

Unfortunately, the freedom and independence of citizens have for a long time been progressively curtailed. The freedom and scope of action of the individual have progressively been diminished as the controls and repressive exactions of government have expanded and multiplied.

Government, by slow and relentless steps, has—in the name of necessity—infringed upon the right of the individual citizen to direct and manage his own life, especially as regards his personal and domestic finances. Under the stimulus of greater and greater income, derived through heavier and heavier tax programs, government at all levels has, year by year, unrestrainedly enlarged its operations and its expenditures.

Hand in hand with the growing extravagance of government has flourished a spiraling inflation, whose effect has been relentlessly to depreciate the buying power of the dollar. The combination has been lethal to the economic independence of the industrious and conscientious tax-paying citizen.

The things that he wants most for himself and his family—such as enough personal wealth to provide well for his family, to educate his children, to meet the costs of illness or misfortune, to insure his own independence and well-being in old age, to leave some money to his children and grandchildren to give them a start on the road of life—all have become progressively difficult, if not impossible, to realize. Not that such a citizen has failed to earn the means to achieve these objectives, but because a large portion of his money has been taken from him in constantly increasing taxes, and what money is left to him has so little purchasing power that it is just enough to enable him to procure the things necessary for day-by-day living, with little or nothing left over for extras of any kind.

In consequence, the average industrious and conscientious tax-paying citizen is, perforce, taking such good care of his government that in many areas he is no longer able to take good care of himself and his family. The effect has been injurious upon our family life. When, after withholdings and taxes of all kinds, the breadwinner counts what he has left, he not infrequently discovers that it is insufficient, not only for extras, but for the costs of everyday basic living for his wife and children.

The upshot is that his wife takes a job to add to the family income, with consequent inevitable neglect of their children and with consequent weakening of the substance of their family life, affections, and disciplines. In a home where there is no mother available to care for the children, there is, of course, no one available to take care of an old relative—no matter how deserving.

So the cry for more care—at extravagant governmental rates—for neglected children and old folks goes up. And if that care is forthcoming, it will mean more taxes, and consequently less individual independence, security, and freedom . . . And the last state of the industrious and conscientious taxpayer becomes worse than the first.

The really important human and social needs of the people over sixty-five—those that I early enumerated—hungers of the heart and of the spirit—are not being met today in our country, because the costs of government are so great as to take from our citizens the means of meeting those human and social needs.

Good American citizens should be, and are willing to support their government financially within reasonable and proper limits. They created it, and they *should* support it. But government should serve, not prey upon, the citizens. Our government was established to insure the freedom and independence of the citizens who established it. It should never be permitted to impair or destroy that freedom and independence; and at the present time, it is doing just that.

It is not only the people over sixty-five who are being deprived of the means of gratifying their human and social needs. We all are. The problem for everybody else is not being adverted to at the present time. It isn't regarded as politically expedient. But in time it will be so clamorous and demanding that it will have to be recognized. Why not think about it now?

IN THE AREA OF PHYSICAL NEEDS

C. Byron Blaisdell, M.D., Chairman, Council on Legislation

Asbury Park

Mr. Chairman, distinguished guests, ladies and gentlemen:

In speaking of "The Problems of the Aged . . . In Fact and Fancy, In the Area of Physical Needs," the reply of the late Dr. Frank Lahey after a particularly flattering introduction comes to mind: "I hope that all the wonderful things just said about me are not true —for, were it so, I should have no future."

This reply seems appropriate for this occasion, because it is my intent to bestow praise and not disparagement upon New Jersey for its accomplishments—of its legislators, its health professionals, and all its dedicated public-minded citizens.

By the many yardsticks for appraisal, such as vital statistics, New Jersey's geographic and communications' advantages, the ratio of hospital beds, and trained and qualified health professions to the population, the number of nursing homes and first-aid squads, of volunteer home-care programs, and a dozen more, New Jersey affords a security to its citizens which can be matched in few states—and probably surpassed in none.

But, like Doctor Lahey, we cannot feel complacent, overwhelmed by our own praise, nor missing the challenge of both the present and the future.

The progressive development of our state (which ranks seventh in wealth in the nation) must be constant and searching in providing a favorable climate, to enable its citizens best to meet their *own* needs, and to help those who cannot.

The need for medical care is intensified in the absence or inadequacy of food, shelter, and clothing. These three needs are at least of equal importance with medical care and because of their effect upon the need for medical care should be at least equally stressed.

It is, perhaps, time we should define what the basic physical needs of the aged may be: There are four basic needs. All human beings need (1) food, (2) shelter, (3) clothing, and (4) a healthy environment. These constitute the basic physical necessities of young *and* old, varying from the bottle and the triangular garment of the infant to the cane and artificial dentures of the aged.

Also, it is desirable—I think—to distinguish between *need* and *desire;* between deprivation and limited resources. We concern ourselves here today with *need*—as involving those things whose lack creates a condition of deprivation. And I would further submit that there has not been established any widespread inability of people over sixty-five to satisfy their own physical *needs*, either from their own resources or by help from family or relatives. For those who cannot, a prominent analyst states recipients of public assistance, under the federal law (as changed in 1950)—and regardless of age or category of need, ranged from 6.2 per cent of the population in Mississippi to "the bright spot in the nation, 0.9 per cent in New Jersey." The New Jersey Commission on page 17 states that 4.1 per cent or one out of 25 of the 465,000 over sixty-five get old age assistance in New Jersey, and maybe better than that, since 350,831 are on Old Age and Survivors' Insurance.

There is not much question as to the fundamental or basic *availability* of these four physical necessities, especially food, shelter, and clothing in New Jersey. Deaths from (1) starvation, (2) lack of shelter, or (3) clothing do not occur because of scarcity or unavailability. And county medical societies, in all twenty-one counties, report not one case demonstrated—in the past two years surveyed —where necessary medical care has been denied because of inability to pay.

Figures from an as yet unreleased survey will show that, in New Jersey, people over sixty-five see and pay private physicians—this must be out of an IBM computer—3,373,204 times per year, which would be 78 visits per patient if all of the 440,000 oldsters, or 465,000, depending on where your figures come, were averaged—3,373,000 calls by people over sixty-five to the physicians. It's over 18 million for all people.

In conjunction with payment for hospital services, two typical New Jersey general hospitals report:

(*Hospital No.* 1) "Of those aged 65 or over, 81 per cent admitted were covered by some type of hospitalization insurance or were financially able to pay the bill. Nineteen per cent were classified as indigent and unable to pay and therefore eligible for assistance from county funds."

(*Hospital No.* 2) "During the months of January and February, we admitted to this hospital, 168 patients over 65 years of age. Of

this number only two were indigent patients. The indigent patients were willingly taken care of by our physicians without remuneration."

In Monmouth County, doctors in one hospital gave 58,000 hours of free services in one year, in the tradition of medicine, which—this may be facetious—at three dollars per hour, would be a contribution of about $174,000 from a small group. This raises the question: Is charity getting to be so wrong? Is help thy neighbor to be outlawed?

The poorest migrant, stuck on the highway, will soon be sheltered, clothed, nourished, and receiving medical care—quickly, expertly—in a way no country in the world could surpass or probably equal.

Is New Jersey low in hospital and physician resources? The answer is "no." In the so-called Bane Report to the United States Surgeon General (H.E.W.) in 1959, with respect to available physicians (and hospital beds), it is stated: "New England, the middle Atlantic States, and the Pacific States have retained high ratios of physicians to population as population grows." New Jersey is in the top ten for the entire United States, with 125 physicians to each 100,000 population—approximately 1 to 800 people. On page 7 of the same report, re hospitals, it states: "Since 1930 the number of beds in the United States in general and allied special hospitals has increased more than 70 per cent. In relation to the population, these beds have risen from 3.7 to 4.6 per 1000 persons." New Jersey's state desired ratio is 4.5 and, with the tremendous hospital building program in our state, we rank very high in the country.

Consider the following for New Jersey. In the past twelve years, New Jersey's general hospital beds have increased by 33 per cent to nearly 20,000. When it is considered that seventeen general or proprietary hospitals have ceased or closed in that time as larger and more modern hospitals have arisen, the accomplishment is qualitatively even greater. Ninety-two per cent of our hospital beds are fully acceptable by high standards.

In mental hospitals, where our approximately 19,000 beds are admittedly low, the beneficial effect of tranquilizers or new psychopharmaceuticals makes a slow approach to expansion worthy of consideration. And the inclusion of mental facilities in thirteen general or community hospitals is a commendable trend worth watching. The interest in mental health in New Jersey for young as well as the aged is great.

Nursing homes for the aged in New Jersey have standards which are the highest in the country, but their application is slow and our resources, though numerous, are admittedly inadequate. General hospitals are reluctant to add chronic beds—understandable when one considers the many serious problems confronting them. Constant scrutiny of the services to the aged in proprietary homes where profit is the motive must be and is systematically given by the Department of Institutions and Agencies.

Ambulance and first-aid squads, most of them *voluntary*, are abundant and well-trained, and when we consider New Jersey's (1) size (45th in the nation), (2) its excellent highway system, and (3) the distribution of its hospitals, the aged enjoy a security, in illness or accident, equalled by no state in the union.

I shall not speak at length of dental or nursing services, since these two professions can well attest to their degree of adequacy and their constant advances in performance and numerical strength. The health careers project is another instrumentality for these and our own advances, and is a new asset to our state. And let us not omit the background protection and comfort afforded by the Red Cross, the Salvation Army, the cancer and heart associations, and the truly remarkable rehabilitation services available to our oldsters.

And another big asset to the security of the aged has thus far not been mentioned. The State Department of Health, with its strong Division of Chronic Illness, its educational projects and participation in care of the aged —such as glaucoma, diabetes, "stroke," blindness, arthritis (to name a few) is a strong arm of protection for those called "aged." Strengthened by Commissions on Air and Water Pollution, Radiation Protection, and the Administration of Public Medical Care, the Department of Health performs, day in and day out, duties little understood and inadequately appreciated by most of us.

What is the population over sixty-five in New Jersey? As of July 1, 1959, we believe it to be about 440,000 people or 8.1 per cent of the population. Of these, 135,000 persons are 75 or over.

Do they receive adequate medical care? We believe they do, for the most part. All others could if it be sought or if they be helped to get it.

Are they able to take care of themselves? The great majority with family help can, as shown by hospital admissions and private physicians' experience. Voluntary agencies, public agencies, and cooperative team-work take care of the rest. And their health environment is protected by the many previously enumerated standards.

Can we improve the living conditions for the aged in the four areas of basic needs? Most certainly we can and must. And let it be said that New Jersey is doing this, has been doing it, and will continue to do so.

In our vital statistics—by the strength of health personnel and facilities, by the organization of a vast army of volunteer and governmental agencies, and the evidence of New Jersey's state government to perfect and accelerate the security of the aged—we have surpassed most states; equalled the top-ranking states; enjoy leadership in many specific fields. Let us not be stampeded into reaction to decry that which is already excellent.

In conclusion, like Doctor Lahey, we have done superlatively well but we still have a future and a challenge. We need no revolutionary changes to improve our methods, we need no increased governmental intrusion into the lives of self-determining citizens—old or young, and we need no compulsory regulations for, or political capital made of, a splendid group of oldsters whose very existence is a tribute to the high standards of living they enjoy.

Utopia is a dream-state, which draws us on and on. It will probably never be reached, but it challenges our minds and our hearts as we steadfastly continue the march. So—good friends—let us march on!

IN THE AREA OF ECONOMIC NEED

William deV. Washburn, President, American Health Insurance Corporation, Baltimore, Md.

My date of birth was May, 1911. Therefore, according to the social planners, I do not yet face the problems of aging. This is, of course, a fallacy, as I am one day older today than I was yesterday. Some days it seems I age more than one day and some days less, but it is a more or less continuous process and does not start on my 65th birthday.

Had I been born in May of 1895 instead of 1911, however, they say I would suddenly, this month, become aged. Not only would this immediately present me with some economic problems that I could not possibly have expected and avoided; the problems would be of such magnitude as to not be solvable by me at all.

In fact, I am not supposed to be capable of meeting them with the help of my family, or of my neighbors in Anne Arundel County, or even with the combined help of over 3,000,000 fellow Marylanders. This includes some good doctors, in my opinion. I have yet to hear of a case of even an impoverished, underprivileged and perhaps unintegrated, fellow Marylander who was known to be shiftless, improvident, dishonest and unsober before he was 65 having been denied the necessities of life, including medical care, in my state, because he is now past 65. I assume that at worst I would be treated as well as he. I expect you New Jersey people are almost as civilized as Marylanders, too, in this respect.

Nobody, but nobody, the social planners say, can help me with this problem, except the benign federal government, which they say can do more for me than all of the combined efforts of myself, my family, my neighbors and my fellow Marylanders.

If my Uncle Sam were that all-powerful, I don't think he would be demanding that I support him. In fact, if I didn't work so many days each year to support my Uncle Sam, I could not only support my immediate family in the style to which they claim to be entitled, I could take care of my wife's parents, and two more wives and their parents too. All by myself, without help even from my fellow Marylanders. And I would have a lot of money left over.

Let's consider those of our fellow Americans who were so unfortunate as to have been born before May, 1895 and thus are now supposed to be such a national problem.

First, they are not average, economically. Far from it. Their needs are normally modest, economically. They have already paid the heavy expense of raising a family. Usually their homes are paid for, also. A recent survey made by the National Conference of Catholic Charities in three typical industrial worker parishes of large cities (St. Louis, Cleveland and Buffalo) showed a substantial majority of the aged owning their own homes. The highest was 74 per cent, in St. Louis. As you probably know, the percentage of home-ownership is usually larger outside of the big cities.

Almost 3/5 of non-married or widowed retired workers are able to live outside of institutions and not with their children. Only 4 per cent of them live in the homes of relatives. Widows entitled to Social Security Survivor Benefits are more likely to share a home with relatives, but even among these one-half do not.

You can be easily misled by statements which quote the average income of an aged person on an individual basis. You see, like younger people, they are more apt to live in family groups, with husbands or wives or brothers or sisters or even widowed friends. The only pertinent average income I can quote, though, is that of retired couples, which is probably less than the average of the other family units among the retired. H.E.W. reported that such couples in 1957 averaged $2,190 per year. But that included the indigent, so the average of those who had some income must have been much higher. Also, that figure did not include income in kind or non-monetary assistance from children, although three out of ten are known to receive such help. Remember, too, that Social Security benefits and most other pension income is tax free, and the older folk receive some special deductions on other income because of their age. It is rather obvious that the total income of the typical family unit over age 65 in retirement is much more than the $2,190 expressed.

But I've been talking only about the people over 65 who have retired. Perhaps I have given an impression that earnings always stop at 65. Well, almost 25 per cent of all men over 65 still show wages or salary as their main source of income and another 15 per cent are still self-employed in business, farming or a profession. That is 40 per cent of our citizens over age 65.

Age does not bring with it a problem of indigence of such magnitude as is generally believed, either. Of the 14 per cent of Americans over 65 whose main source of money is public assistance, quite a few received such assistance long before 65. Age is not the only cause of their financial problems.

Actually, a young family man earning an income substantially larger than that of his retired parents is apt to be relatively less well off than they, in view of his responsibilities. We would probably find plenty of cases of such families receiving help from their aged parents if we looked.

You see, when we compare the typical income of our older people with the incomes they received during their earlier years while they were starting to raise families and starting to pay off home mortgages and buy life insurance and so forth, we see a pretty favorable comparison. Since they don't have these drains on income they should be at least as well off, or at worst they should have no serious economic problems as a group, caused by their having been born before May of 1895.

Then why all the hullabaloo? Why aren't they better off than their own parents had been at the same time of life? Why are they hurting, economically?

Make no mistake on this score. They are hurting, economically. I don't like to trespass into the subject of social needs, which is not my province today, but a great many of these older people, and that includes my wife's parents, had expected to be able to help their own children and grandchildren after retirement, and leave their accumulated savings or a substantial portion of them to their families. Don't you hope to be able to do this same thing?

Instead of this, they now fear the need to depend on their children or, even worse, on the government for help during their retirement years. This is a loss of dignity that is difficult to express, economically.

What went wrong? Will it get worse? Can anything be done about it? We cannot ignore their plight. These folk are hurting, economically.

Do you note a similarity between their questions and those of the patient who comes to you with a painful symptom. He hurts. Why? Is this not your first question? Why does he hurt?

The economic discomfort or even pain experienced by our older people in our country is a symptom of a disease. It is an economic disease. It is an insidious, progressive, economic disease. It is the public disease of inflationary spending and taxation, of inflationary federal subsidies to groups of voters, of the progressive and insidious disease process of tax and tax, spend and spend, elect and elect. The physical disease to which it is most similar is cancer. Unchecked, this economic disease leads to complete economic collapse, chaos, death of civilization based on free individual choice.

You see, the growing tax burden, though still mostly hidden, acts to keep an individual from accumulating for his own old age or helping to provide for the old age of his parents. The inflation both deters him from saving and steals away the value of what he does save, as well as what was saved by his parents.

It is the erosive effect of inflation on the

purchasing power of the pensions, insurance, and savings to which our older people have become entitled in their latter years, because of their efforts during their earning years, that constitutes the underlying disease problem of our senior citizens today. Ask any one of them what his problem is. In one way or another, you will get this answer.

This disease, truly a public health problem, threatens not only our old folk but all of us, our children and those yet unborn. Remember, we are aging, day by day.

The problem of paying for needed health care in retirement years is only one facet, only a part of the symptom, of their problem of stretching dollars to which they became entitled during their productive years to fit today's prices, or what may be worse, tomorrow's.

This is a tragic problem and it involves you, personally. You and I are faced with this, though we may not see it yet, or perhaps we may be among those who somehow feel that more "free" government expenditure may magically cure the disease which it caused.

There is nothing wrong with treatment directed at relief of pain, as long as the treatment does not interfere with or, by masking, prevent the removal of organic cause of pain. I don't say we should ignore our senior citizens' economic pain, either.

But, what is your opinion of a man who calls himself a doctor, who goes around treating symptoms, not looking for the underlying causes or if he sees them, doing nothing about them? Are you that kind of a doctor?

In a democracy, economic disease must be cured by the citizenry, the voters, in the last analysis. This is you and I and others to whom we talk. Our representatives may be expected to be "politically expedient," especially in election years. Are we going to continue to let them treat symptoms, ignoring the need to search for underlying causes or, when the causes are evident, doing nothing about them? Do we believe that we have any lesser obligations as citizens of our country and of this world than we have as members of our profession, whatever that profession may be?

Each of us is first a man, second an American citizen, and third a business executive or factory worker or doctor.

To even imply that it is beneath our dignity or unethical to combat in the political arena those socialistic labor leaders, federal social planners, and political demagogues who would treat symptoms and ignore underlying disease in our economy is to imply that it is beneath our dignity or unethical to be good Americans. To me this is an inescapable truth. Regardless of occupation, profession or political party, but as a fellow American, I hope you will agree.

THE BALANCE THAT IS POWER . . . TO SURVIVE

David Eckstein, M.D., Secretary, New Jersey Joint Council to Improve the Health Care of the Aged, Trenton

Dr. McCall, Dr. Buchanan, fellow panelists, ladies and gentlemen: I come before you in humility with little more than sincere, deep convictions about a matter to which I have given serious thought. I trust that my thoughts may stimulate resolute action.

We would be extremely foolish to say that problems for the aged do not exist. When we of the medical profession, and the allied professions, attempt properly to place the responsibility for the development of these problems, then we are showered with abuse and accused of crimes against society too numerous, and ridiculous to mention. And we must expect abuse since practically all proposed so-called social legislation has been aimed at vitiating the very characteristics which made this country strong—free enterprise and self-determination within the limits of the law and the Constitution. So we are now faced with powerful appeal to sentiment that we must do something for some 16 million souls over 65—whether or not they need it—and the cost be damned! Presently proposed legislation will cost between 1.5 and 2 billion dollars for the first year and after that it's anyone's guess. Where is the money to come from, you ask? Just up the taxes—and up—and up—and soak him, who through initiative and hard work has a little more than the next. Whether they want to or not, let everyone pay and a minority group—but as yet undetermined and unidentified—reap the benefits. There will be a reward for improvidence and outright irresponsibility.

Permit me to quote from Thomas Jefferson —"I place economy among the first and most

important virtues, and public debt as the greatest of dangers to be feared . . . To preserve our independence, we must not let our rulers load us with public debt—We must make our choice between economy and liberty or profusion and servitude—If we can prevent the Government from wasting the labor of the people, under the pretense of caring for them, they (the people) will be happy."

It is in this regard that we, as citizens, must raise our voices. We are entitled to ask: Just how much more of our income can the government take without precipitating disaster? We are courting disaster now and rockets and H-bombs won't be necessary. Of one thing you can also be sure—you provide the income and the government will find the means to spend it. As to the particular problems now under discussion, no one knows just how much of these estimated expenses are really necessary. You will recall that, at present, all over the nation, committees and commissions on aging are assembling facts and figures in preparation for the White House Conference on Aging to be held in 1961. But this is an election year and nothing, not even the simplest logic, must delay a decision and whopping big give away—according to many who have John Q. Public's ear. This impetuous approach—and I believe that this is a very constrained description—is totally foreign to us as medical practitioners. We don't like to prescribe treatment before we have a diagnosis and an estimate of its severity. We can't in good conscience approve of plans which involve huge expenditures of money when we don't yet know for whom, for how many, and for what. Lenin prophesied that we would spend ourselves to destruction and those who seem most instrumental in determining national policy are certainly trying to prove him correct.

The privilege of a dissent carries with it the responsibility of offering an alternative. We do not have a pat plan by which 16 million people will be educated, medicated, rehabilitated and, most of all, dominated! We believe that the problems of the aged should be solved, whenever possible, where they exist—in the community or geographic area. The free enterprise system of individual self-care, individual family and community responsibility must be redeveloped to its fullest. Then, and only then, should the Federal government—if needed—enter the picture and then only as a silent partner and not as the controlling agency. As far as medical care is concerned, the medical profession never has defaulted and never will default on its promise to care for all who are unable to pay.

As physicians we have still another battle which might well help to maintain the balance which could well mean the survival of the individual and the nation. Look back a decade or so and note what has happened to the man who, by the Grace of God, has been afforded the now dubious privilege of passing his 65th birthday. Through compulsory retirement he is, literally overnight, a superfluous oldster rather than a proud part of a working team. With a sharp reduction in income and exclusion from the job, his confidence begins to melt. When he receives his Social Security benefits, he is informed that he can earn only so much additional—the remnants of security go out the window—and the rest is all socialized. But he needn't worry, Washington is thinking of him—and expensive thinking it is—and Washington is now readying a new home for him—his own is too big and too old—and too comfortable; and finally he is now thoroughly convinced that he needs an ambitious program of health care even though he's had hardly a sick day in his adult life. By indirection, his children—for whom he worked and saved—these same children now logically draw the conclusion that the parent or parents are neither their moral or legal responsibility. The beneficent government will take care of everything—including initiative, pride in a job well done, and the good garden variety of American guts. We are watching the destruction of the family unit with its mutual assumption of responsibility just as surely as if the Chinese Communists had planned it.

We doctors, in our day to day contacts, must help to rebuild some of this damaged self-confidence and replace some of the lost dignity and prestige which should go with advancing years. We need look no further than staff practices in some hospitals where the senior citizen is made emeritus at 65. In itself this is not important. But all too often the title of Emeritus—defined as retired from active service but retained in an honored position—is meaningless and empty and all those years of experience and seasoning are held in disdain because of an arbitrarily set age level. As physicians we must sell all elderly people that they still occupy an important place in the community and that age 65, 70 or 90 does not necessarily mean a mental, physical or physiological black-out. We must not permit the growth of the pernicious philosophy that the arbitrary age level of 65 means senescence. We must preach the obvious truth that self-help is the best help at no matter what age.

To further tip the balance in favor of sur-

vival, we must realize that the obligations of a doctor are not met solely in the practice of medicine. We are endowed, I believe, with better than average ability and better than average education. We are trained to view things in a bright dispassionate light and we must be decisive and determined, else we are poor physicians. These qualities are necessary to good community leadership also. We must sit in the councils and must let our voices be heard in the meetings. Our retiring president is an ex-mayor. This is the epitome of good citizenship. If we abstain, we lose the battle by default. If we join and help to clarify muddled minds and let our thoughts be known, we will be helping to build a healthier, happier and eminently better United States of America.

Medical Military History Available

Many of the medical military lessons learned in 1917 and 1918 had to be relearned under fire during World War II because of the meagre distribution of the World War I medical history.

Lieutenant General Heaton, The Army Surgeon General, in an effort to prevent this costly relearning process, in the unhappy event of another war, has directed the preparation and distribution of the "History of the Medical Department, United States Army, in World War II."

Of the 48 volumes programmed for the series, 15 have been published and can be purchased from The Superintendent of Documents, Government Printing Office, Washington 25, D. C. The 15 volumes are available at $66.50. Individual volumes can be obtained at low prices. Commanding officers of medical units may requisition copies for their libraries by submitting DA Form 17 to The Historical Unit, U. S. Army Medical Service, Washington 12, D. C.

Volumes now available are:

"Emergency War Surgery" ($2.25)

"General Surgery"—Edited by Michael E. DeBakey, M.D. ($4.25)

"Neurosurgery," Volume I (Head Injuries)—Edited by R. Glen Spurling, M.D. and Barnes Woodhall, M.D. ($5.00)

"Neurosurgery," Volume II (Spinal Cord and Peripheral Nerve Injuries)—Edited by R. Glen Spurling, M.D. and Barnes Woodhall, M.D. ($7.00)

"Hand Surgery"—Edited by Sterling Bunnell, M.D. ($3.75)

"Ophthalmology and Otolaryngology"—Edited by M. Elliott Randolph, M.D. and Norton Canfield, M.D. ($5.00)

"Orthopedic Surgery, European Theater of Operations"—Edited by Mather Cleveland, M.D. ($4.00)

"Orthopedic Surgery, Mediterranean Theater of Operations"—by Oscar P. Hampton, M.D. ($4.00)

"Physiologic Effects of Wounds"—Edited by Fred W. Rankin, M.D. ($3.50)

"Vascular Surgery"—Edited by Daniel C. Elkin, M.D. ($4.25)

"Cold Injury, Ground Type"—By Tom F. Whayne and Michael E. DeBakey, M.D. ($6.25)

"Dental Service"—By George F. Jeffcott, D.M.D. ($3.25)

"Environmental Hygiene"—By James Stevens Simmons, M.D. ($3.50)

"Personal Health Measures and Immunization"—By John E. Gordon, M.D. ($3.25)

"Communicable Diseases," Volume IV—By John E. Gordon, M.D. ($5.50)

"Hospitalization and Evacuation, Zone of Interior"—By Clarence McKittrick Smith ($4.00)

"Army Medical Statistics"—By A. G. Love, M.C. ($2.00)

You may buy individual texts by sending your check to Superintendent of Documents, Government Printing Office, Washington 25, D.C.

You may donate the entire set (15 volumes) to your favorite hospital or medical society library—in your name—by purchasing them as a set for $66.50.

Announcements • • •

Surgeons and Nurses Meet in Philadelphia

Surgeons and surgical nurses are invited to attend a four-day seminar at the American College of Surgeons meeting in Philadelphia starting March 6, 1961. The program includes a set of novel "How to Do It" clinics, as well as moving pictures, colloquia, demonstrations and panel discussions. Noted surgeons from all over the western world will be there to talk, exhibit or discuss. Every subspecialty of surgery will be represented. For full program, write to American College of Surgeons at 40 East Erie Street, Chicago 11, Illinois.

Advances in Medical Practice

The Albert Einstein Medical Center announces a Wednesday afternoon course covering important advances in selected areas of current medical practice. The course starts on January 18, 1961 and terminates on April 5. It will be held every Wednesday afternoon from 2 to 5 p.m.

For more details write to the Albert Einstein Medical Center, Philadelphia 41, Pa.

Endocrinology Seminar

Saturday, January 14, 1961 has been selected as the day for a colloquium on endocrinology under the sponsorship of the New Jersey Chapter of the American Academy of General Practice. The seminar will be held at the Traymore in Atlantic City, starting at 10 a.m. and concluding at 5 p.m. A special program has been provided for the ladies. In fact, even baby sitters will be provided.

Topics covered: (1) The anterior pituitary; (2) Thyroid disease; (3) Diabetes; (4) Disorders of the adrenal; and (5) The use of hormones. A star-studded faculty has been obtained, and time is allowed for questions from the floor. The AAGP allows 5 hours category I credit for this program.

For more details, write to Academy of General Practice at 120 Halsted Street, East Orange, N. J.

Polycythemia and Neoplastic Disease

Your cooperation is requested in a study of the association of polycythemia with neoplastic disease being conducted by the National Institutes of Health. An elevation of the circulating red cell volume in the absence of leucocytosis and thrombocytosis has been noted with renal tumors, cerebellar hemangioblastomas, uterine fibroids, pheochromocytomas, and other neoplasms. An erythropoiesis stimulating factor has been demonstrated in homogenates of certain tumor tissue. This study has as its purpose the determination of the nature and mode of action of the erythropoiesis stimulating factor produced by these tumors.

Patients admitted to the study undergo a period of evaluation including the determination of the circulating red cell volumes, red cell life span and the rate of red cell synthesis. Plasma and tumor tissue, if available, will be assayed for erythropoiesis stimulating activity.

Physicians who wish to have their patients considered for this study at the National Cancer Institute may write or call:

DR. THOMAS A. WALDMANN
National Cancer Institute
Bethesda 14, Maryland
(OLiver 6-4000, Ext. 3667)

County Society Reports • • •

Atlantic

A regular meeting of the *Atlantic County Medical Society* was called to order at the Children's Seashore House by President Harvey Vandergrift on October 14. Our program chairman, Dr. Josiah McCracken, presented the speaker, Dr. John Frost, Chairman of Hematology at the University of Pennsylvania.

Dr. Frost discussed the problem of anemia, giving us an excellent review of the classification of anemias, their causes, mechanisms and treatment. It was a lively and interesting scientific presentation.

Dr. Clarence Whims read a resolution in memory of Dr. D. Ward Scanlan. The society also paused in respect to the passing of Dr. Charles D. Sinkinson.

Dr. Joseph Stella announced that the County Loan Fund is now prepared to consider applicants for the second annual loan. Dr. Peter Marvel announced that Dr. DeSantis has been accepted into our County Society as a transfer from the Cumberland County Medical Society. Dr. Edgar C. Bristow has been accepted as an associate member and was introduced during the meeting.

Dr. John Holland suggested that each member help secure advertisements for our County Society *Bulletin* to help build up the reserve for our loan fund.

Dr. Holland announced that the professional liability insurance endorsed by our State society is now available to members.

We were all proud to learn that the American Medical Association has again selected Atlantic City as the site for its 1963 convention, with much of the credit, of course, going to our own Dr. David B. Allman.

LEONARD B. ERBER, M.D.

Reporter

Bergen

The regular meeting of the *Bergen County Medical Society* held October 11 at Bergen Pines Hospital, Paramus, was called to order by George O. Rowohlt, M.D., President, at 9:05 p.m.

The Secretary read the following names which had been approved for election to membership:

To Active—Francis Mathus, Joseph W. Sloan, Elizabeth M. Bogardus, Carmelo Cimillo, Fernando Garip, Michael G. Salz, and William M. Sweeney; To Courtesy—Edgar M. Housepian and Herbert P. Vogel; To Associate—Richard A. Botta, Michael R. DeVita, Marie N. DeVita, Stanley S. Friedman, Andre Heltai, Henry R. Hoff, George W. Keyes, Stanley D. Machlin, Pasquale Serpico, and Sidney W. Winchell; Leave of Absence—Peter Pagano (due to illness), and Sidney W. Winchell (military service).

It was moved and carried that the Secretary cast one ballot for the election of the slate.

The Secretary made the following announcement: The Woman's Auxiliary will hold a *Monte Carlo Night* party at the Hackensack Golf Club on November 5, with dancing, buffet supper, stage currency gambling, and an elaborate setting reminiscent of Monaco—charge $12.50 per capita.

Dr. Richard P. Keating, chairman of the Program Committee introduced the speaker, Mr. Charles Noble, Special Representative of the U. S. Chamber of Commerce. Mr. Noble recounted the legislative activity of the National Chamber in combating the Forand Bill and other Socialistic free spending legislation and asked that this Society become a member and that individual physicians "sign up."

Dr. Phoebe Hudson, chairman School and Child Health Committee, discussed examinations of school children being done by family doctors rather than the school physician. Bill S-47 was introduced in the State Legislature but died in committee. This bill will be reintroduced. It would allow for the acceptance of family physician routine health examinations *on a permissive* basis by local school boards. This is not mandatory but would free the school physician from routine examinations, allowing him to concentrate on the children with physical problems. It would provide for more thorough examinations which would be recorded on forms to be given to each school child by the school and which would be completed by the family doctor. Her committee is contemplating a seminar for school physicians sometime during the year. Dr. Hudson displayed a pamphlet entitled "Recommended Standards for School Health Services" which will be distributed to all school physicians about the end of this month.

New Professional Liability Insurance—Dr. William Palazzo, chairman of this Society's Insurance Committee and member of the State Society's Committee on Medical Defense and Insurance, discussed briefly the new professional liability insurance contract now being offered by the American Mutual Liability Insurance Co. He urged each of our members to change his carrier to the new authorized insurance company.

The regular meeting of the *Bergen County Medical Society* held November 8, at Bergen Pines Hospital, Paramus, was called to order by George O. Rowohlt, M.D., President, at 9:05 p.m., in the presence of 57 members.

There being no additions or corrections to the minutes of the regular meeting of October 11, and

the Executive Committee meeting of October 18, as printed in the November 1960 *Bulletin*, they were accepted and filed.

Membership certificates and wallet identification cards were presented to Active members elected at the last meeting and Associate members were introduced.

The following were elected to membership: *To Active by Transfer*—Maurice F. Deraney (from Medical Society, County of N.Y.;) *To Active from Associate*—Gerald R. Frolow; *To Associate*—Edouard P. Beaugard; *To Courtesy from Associate*—William H. Bristow, Jr. (member-Passaic County Medical Society); *Leave of Absence*—Martin G. Blechman—for 1 year for postgraduate work.

The Secretary displayed the current Bergen County Directory of Social, Health and Welfare Agencies compiled by the Bergen County Council of Social Agencies. These directories may be obtained from the Society Headquarters Office.

The Chair asked Dr. Samuel B. Reich to present the scientific program. Dr. Reich introduced Dr. Emanuel Klosk, secretary of the New Jersey Chapter of the American College of Chest Physicians, and the panelists—Dr. Coleman B. Rabin of Mt. Sinai Hospital, New York City, and Drs. John L. Olpp, William L. Palazzo, Herbert S. Sharlin, members of our Society. Each member was called upon to present an unusual chest x-ray from one of his patients. Another member was then called upon to discuss the plate and make a differential diagnosis. This was followed by a critique by Dr. Rabin and comments from the moderator, Dr. Klosk.

CHARLES P. CAMPBELL, M.D.

Reporter

Gloucester

The initial fall meeting of the *Gloucester County Medical Society* on September 15 was well attended by a majority of the members.

The scientific portion of the program began with a presentation by Dr. Karl Jonas, Surgeon at St. Joseph's Hospital in Philadelphia, who discussed "The Acute Abdomen." Following this well received discussion and a question period, the business section of the meeting was held.

The eighth annual diabetic detection drive was announced. The eighth annual symposium of diabetic research at the Veterans Hospital in Lyons, N. J. was recommended for the calendar of all members. Also announced was an Eye Health Screening Program in the Underwood Hospital under the guidance of Dr. Oram Kline, Jr. A motion was made by Dr. Guy Campo that the county medical society amend its constitution to read: "Every physician legally licensed in New Jersey, who resides or practices in Gloucester County, who is an American citizen, who has received a Doctor of Medicine degree and has attended four scholastic years of medical school, approved by the Gloucester County Medical Society and has letters of recommendation from two Trustees of the Gloucester County Medical Society and one year of internship in a hospital approved for internship by the American Medical Association, shall be eligible for membership in the Gloucester County Medical Society." The motion was seconded by Dr. Regan and passed by vote.

The program committee reported that the October meeting would be the annual social session with our own esteemed member, Dr. Chester Ulmer, as the principal speaker.

WILLIAM D. KEHLER, M.D.

Reporter

Hudson

With Dr. Charles A. Landshof, President, presiding, the regular meeting of the *Hudson County Medical Society* was held at Murdoch Hall, Jersey City Medical Center, on Tuesday evening, November 1.

The speaker of the evening was Dr. Coleman B. Rabin, Assistant Professor of Medicine at Columbia University. Dr. Rabin's subject was "Newer Physical Signs in the Diagnosis of Chest Diseases." Many members participated in a discussion from the floor.

Dr. Harry J. Robinson of Merck Institute, Rahway, was elected to regular Active membership. Drs. Ralph Aloi, Endel Kask, Gaspare F. Saitta of West New York; Drs. Hector Giancarlo, Victor M. Kimel, Jules C. Ladenheim of North Bergen; and Dr. Herbert M. Sinakin of Jersey City were elected to Associate membership in the Society.

The newly elected members were then introduced to the membership.

Following the business meeting, a collation was served.

LOUIS KOSMINSKY, M.D.

Reporter

Middlesex

Roosevelt Hospital was host to the *Middlesex County Medical Society* at its first fall meeting of 1960 on October 19 at 9:00 p.m. The meeting was directed by the president, Dr. Stanley A. Gadek.

Applications of the following were approved for presentation to the Committee on Credentials: Regular membership from two years of Associate membership—Drs. Eugene F. De Angelis, Milltown; Mauro De Girolamo, Parlin; and John H. Sergeant, New Brunswick; and to two-year Associate membership—Paul Curtis, Highland Park; and Charles M. Weber, Woodbridge.

Maurice H. Hilleman, M.D., Director of Merck Institute of Therapeutic Research, gave a highly interesting paper on: "Purified poliomyelitis vac-

Prior to the April meeting, a study will be made of the success or failure of the Index in other states. Representatives of each hospital in the county are to report on how equitable they felt the RVI was in the various specialties.

Dr. Anthony De Spirito and Dr. Irwin J. Polk commented on the rising tide of the socialization of medicine and expressed the urgent need of the medical profession to find ways of meeting and controlling it rather than being swept along with it. One proposal, made by Dr. Charles Zukaukas, was that each county medical society employ full-time paid representation of high caliber to assemble facts and present them before the public, thus explaining our approach to medical care for the aged and other problems, such as the high cost of hospitalization. Dr. C. Byron Blaisdell pointed out that the American Medical Association has, for many years, had highly paid economists and public information personnel working in our behalf in Washington and in trouble spots throughout the nation, where the private practice of medicine has been threatened. Dr. Blaisdell expressed pleasure at the enthusiasm of the participants in the discussion and in their desire to find ways of preserving our high standards of medical care through the voluntary doctor and patient relationship.

LEONARD S. DANZIG, M.D.

Reporter

Monmouth

The October meeting of the *Monmouth County Medical Society* was called to order by President Morton F. Trippe at Monmouth Medical Center, Long Branch, at 9:15 p.m. on October 26.

Elected to Associate membership was Dr. Barry N. Grabelle of Eatontown. The business meeting was concluded with a decision to establish a committee to investigate the proposed "Doctors' Hospital" in Eatontown.

The meeting was then turned over to Dr. John F. Stockfisch, program chairman, who led a Forum entitled "Profession of Medicine: Unionized? Socialized? Independently Unified?" The New Jersey Relative Value Index proposal was again discussed. Its opponents felt that this plan would allow third parties to dictate our fees. Those in favor of the index considered it a guide to young physicians entering practice and as a means of disciplining doctors who charge excessive fees. A proposal to approve the Index was laid on the table, to be voted upon at the April 1961 meeting. At that time, our delegates to The Medical Society of New Jersey would learn the County Society's wishes.

cine and monkey virus." The killed virus is chemically precipitated and separated by an ultracentrifuge. A more virulent strain of type I virus is used in place of Mahoney strain. Two-dose immunization injections result in better than 90 per cent conversion of antibody titers. The process removes all monkey kidney substance and results in removal of fear of future nephrotoxicity with multiple injections. Process also removes newly discovered monkey kidney virus and the theoretic threat of long term oncogenic effect.

The meeting was adjourned and collation served.

THOMAS I. STEINBERG, M.D.

Reporter

Morris

The first regular fall meeting of the *Morris County Medical Society* was held October 20, at the Warner-Lambert Pharmaceutical Company in Morris Plains. Speaker of the evening, Dr. Maurice Costello, Professor of Dermatology, New York University, discussed "Common Problems in Dermatology." A question and answer period followed the lecture.

Officers for the current year elected at the June meeting were: *President*—David P. Williams; *Vice-President*—Lexter B. Blake; *Secretary*—Adolph R. Wichman; *Assistant Secretary*—Morris Dirdack; *Treasurer*—Henry O. von Deilen.

Following the meeting which was well attended, collation was served.

CHARLES C. SCOTT, M.D.

Reporter

Passaic

The regular meeting of the *Passaic County Medical Society* was held on Tuesday, September 20, at 9:00 p.m. at the Alexander Hamilton Hotel. The president, Dr. F. Albert Graeter, presided.

The following were elected to Associate membership—Drs. Jerald M. Spivak of East Paterson, John A. Schultz of Paterson, Dean A. Wry, Jr. of Clifton and William H. Bristow of Emerson. Elected to Active membership were Herbert N. Kohn of Passaic and Louis G. Bosco of Clifton. Dr. Ruth Peachey of Passaic was elected to Courtesy membership.

Dr. Frank B. Vanderbeek, Chairman of the Finance Committee, read the report of his committee for the fiscal year. This was adopted as presented. The president then read the Resolution on the death of Dr. Joseph E. Mott, which was adopted as read.

Dr. Joseph R. Jehl said that the Student Loan Fund is in need of money. He recommended that the Passaic County Medical Society initiate a fund to memoralize Dr. Mott; the money to be turned over to the Student Loan Fund. A motion was approved that this Joseph E. Mott Memorial Fund be established.

The president then turned the meeting over to Dr. Edward A. Wolfson, Program Chairman. Dr.

Wolfson expressed his appreciation to the Society members and the members of the Woman's Auxiliary for their attendance at this meeting. He then introduced the two distinguished guest speakers, Congressional Candidates Charles S. Joelson and Walter P. Kennedy. Each candidate expressed his position concerning proposed health legislation. The audience presented written questions to both candidates which were answered during the question and answer period immediately following their talks. The topic discussed by the guest speakers was of particular interest to the membership inasmuch as it concerned possible legislation which could have widespread effect on the medical profession.

A collation was served following the adjournment of the meeting.

The annual installation dinner meeting of the Society was held in lieu of the regular monthly meeting to introduce Dr. F. Albert Graeter as President, and the other officers of the Society. The meeting was held in the Grand Ballroom of the Alexander Hamilton Hotel on Wednesday, October 5.

Dr. David B. Levine, Chairman of the Dinner Committee, opened the meeting by introducing Monsignor Francis H. Murphy, who gave the invocation.

After the dinner, Dr. Levine called upon Dr. Sandor A. Levinsohn, who served as master of ceremonies.

Dr. Levinsohn made the presentation of the plaque which is customarily awarded to the retiring President. Inasmuch as Dr. Cohen was in Europe and could not attend the dinner, Dr. Harry Yolken accepted the plaque in his behalf.

Dr. F. Albert Graeter, the newly elected president, was then introduced and he addressed the audience. He told the members that the practice of medicine has faced a "loss of stature . . . as far as the public is concerned." He called upon the members to keep before the public the facts of contributions the medical profession is making to human progress and emphasized as his goal for this year, "Better Public Relations."

Other officers installed were: Dr. David B. Levine, First Vice-President; Dr. Francis R. Meyers, Second Vice-President; Dr. Marion F. Kaletkowski, Secretary; Dr. Frank B. Vanderbeek, Treasurer; Dr. James A. Rogers, Assistant Treasurer; Dr. Irving Chrisman, Reporter; and Dr. John A. Ianacone, Editor.

Invited guests of the Society were: Dr. Jesse McCall, President, and Mr. Richard I. Nevin, Executive Officer, of The Medical Society of New Jersey, both of whom addressed the group briefly; also Dr. George O. Rowohlt, President and Charles P. Campbell, Secretary, of the Bergen County Medical Society. Other guests included the Honorable Stanley Zwier, Mayor of Clifton and Paul G. De Muro, Mayor of Passaic; Mr. John F. Crane, Director of the Paterson General Hospital; Mr. Harvey Schoenfeld, Director of the Barnert Memorial Hospital; Mr. Joseph A. Mattson, Administrator of the Passaic General Hospital; Mr. David Wachs, Superintendent of Beth Israel Hospital; Martin Klughaupt, Esq., Passaic County Medical Society Counsel; Mr. Richard Drukker, President of The *Herald News*; Mr. Samuel Raff, Managing Editor of The *Morning Call;* Joseph L. Rubenstein, D.D.S., President of the Passaic County Dental Society; Mr. Irwin Sussman, President of the Passaic County Pharmaceutical Association and Harry C. Peterson, Esq., President of the Passaic County Bar Association. It was a pleasure to have as guests the Emeritus Members who could attend: Drs. Andrew B. Vanderbeek, Louis Lipton and Ralph J. Vreeland.

Dr. Levinsohn then introduced the guest speaker, Charles P. Bailey, M.D., Chairman and Professor of the Department of Surgery, New York Medical College and Flower and Fifth Avenue Hospitals. Dr. Bailey's topic was "The Future of Cardiac Surgery."

IRVING CHRISMAN, M.D.

Reporter

Salem

In the absence of the President, Dr. Ford C. Spangler, the regular monthly meeting of the *Salem County Medical Society* was called to order at 4:30 p.m. by Dr. William L. Sprout, Vice-President, October 21 at the DuPont Penns Grove Country Club.

After presentation of committee reports, Dr. Sprout noted the contribution to AMEF by the various states. He then announced that the next meeting on November 18 would be a joint assembly with the Salem County Bar Association. It is hoped that such meetings will foster a better understanding of problems affecting both professions.

After a discussion regarding possible increase in the County Society dues it was agreed that the subject be laid on the table.

Dr. Sprout then introduced the guest speaker Dr. Gardner Jacobs, Clinical Director, of the Salem County Guidance Center. Dr. Jacobs spoke on Current Treatment of Depression.

There was considerable discussion, including a review of electronic treatment, psychotherapy and newer drugs.

The meeting adjourned at 6 p.m.

F. W. WINTERS, M.D.

Reporter

Book Reviews • • •

Fundamentals of Modern Allergy. Edited by Samuel J. Prigal, M.D. New York 1960. McGraw-Hill. Pp. 671. ($18.50)

Knowledge of the basic principles of allergy has made a tremendous contribution to the understanding of the varied and increasing number of diseases related to allergy in its broader concepts. Every physician and medical student will be helped by reading this simple, easy-to-read text, which reviews the sometimes baffling relations of infections, psyche, collagen diseases and auto-antibodies, to allergic manifestations.

Other useful information includes a well-illustrated chapter on pathology, one on the treatment of emergencies in allergy, and a section dealing with the manifestations and forms of allergy.

The importance of a detailed history is stressed, using patience, sympathy, and understanding with the allocation of enough time without interruptions. "A reliable history is more important than a positive skin test." The editor, Dr. Samuel J. Prigal, is Associate Professor of Medicine at Flower-Fifth Avenue Hospital. He had the collaboration of 58 contributors, who are to be commended for their excellent presentations.

ALBERT BASRI, M.D.

Differential Diagnosis of the Electrocardiogram. By Sidney R. Arbeit, M.D., Ira L. Rubin, M.D., and Harry Gross, M.D. Philadelphia 1960. F. A. Davis. Pp. 212, illus. ($10.50)

In 1924, Sir Thomas Lewis published his classic book, "The Mechanism and Graphic Registration of the Heart Beat." Since then several hundred books dealing with electrocardiography have been published. The book now under review is unique in that it uses a different method of presentation of the interpretation of the electrocardiogram. The text starts by summarizing basic principles of electrocardiography and discusses: (1) Electrophysiology of the normal heart; (2) Technic for the taking of an electrocardiogram; (3) The normal electrocardiogram; and (4) Electrophysiology of the abnormal heart.

All four topics are well prepared and clearly illustrated.

The second part of the book covers differential diagnosis. Based on abnormalities of the electrocardiogram, this section, in atlas fashion, considers each isolated change in any part of an electrocardiogram complex; and from that abnormality leads to a differential diagnosis based on the deviation. The authors suggest that their atlas can act as a "Cardiac Consultant" and that a correct diagnosis will be reached in over 95 per cent of cases; an optimistic viewpoint.

The final portion of the book discusses electrocardiographic patterns in specific disease states and the clinical implications of various electrocardiographic abnormalities. The 509 illustrations are well captioned.

This book can be recommended to general practitioners, to internists who have had little training in electrocardiography and to cardiologists as a reference source. There is one definite criticism of such a book, namely, the electrocardiographer should be so well versed in basic principles that he should be able to interpret any electrocardiogram and arrive at a diagnosis without the need of fitting the electrocardiogram to a given pattern.

JEROME G. KAUFMAN, M.D.

Back Pain: Diagnosis and Treatment Using Manipulative Technics. By J. M. Mennell, M.D. Boston, 1960. Little, Brown. Pp. 226 with 78 illustrations. ($9.50)

"Oh my aching back!" has become one of the wails of the modern man. Every one (except physicians) knows that some patients get more relief from backache from certain cultists than they do from the more conventional medical and surgical technics. Dr. Mennell believes that there is a wide range of usefulness for manipulation. The step-by-step manipulative technics are here outlined and diagrammed, but the author stresses the need for intensive training with many months of work on normal backs. There is an excellent chapter on history-taking and another one on diagnostic procedures. There is also a plea for more research in the field of backache. "If our scientists had been as slow in their inquiries into the mysteries of outer space as our profession has been in its inquiries into the mysteries of joint spaces" says Dr. Mennell, "our country would have degenerated into a second rate power."

The author writes with vigor, and whether one agrees with him or not, the book is well worth reading and studying.

HERBERT BOEHM, M.D.

THE JOURNAL

OF

THE MEDICAL SOCIETY OF NEW JERSEY

Index 1960

Society established July 23, 1766
Journal founded September 1, 1904

VOLUME 57

JANUARY TO DECEMBER, 1960

Published monthly under direction of the

COMMITTEE ON PUBLICATION

Fred B. Rogers, M.D., Chairman
C. Spencer Davison, M.D., Vice-Chairman
Jesse McCall, M.D. Joseph F. Mott,* M.D.
Marcus H. Greifinger, M.D. Frank L. Rosen, M.D.
Ralph M. L. Buchanan, M.D.

Henry A. Davidson, M.D., *Editor*

Miriam N. Armstrong, *Assistant Editor*

*Deceased

Editorial Office
315 West State Street
Trenton 8, N. J.

INDEX -- 1960

HOW TO USE THIS INDEX

This is a single alphabetical index. When searching for an original article, look under the first significant word in the title. Authors are also listed alphabetically, with an asterisk (*) to indicate if reference is to an original article. Editorials are indexed by first significant word or title or by subject; book reviews by title or subject but not by author. City of residence is indicated for authors of original articles.

If you do not bind your JOURNALS, use the table of pages (below) to find the month of issue to which any page citation refers.

The annual reports of the committees and officers of the Society and the Transactions of the Annual Meeting appear in the July issue.

TABLE OF PAGES

January	1 to 56	September	511 to 558
February	57 to 106	October	559 to 612
March	107 to 164	November	613 to 674
April	165 to 234	December	675 to 738
May	235 to 288		
June	289 to 344		
July	345 to 448	Annual Reports	July JOURNAL
August	449 to 510	Transactions	July JOURNAL

KEY TO SYMBOLS

* Original Article
† Obituary
e—Editorial
br—Book Review
ab—Abstract

INDEX --- 1960

A

Abortion, Pathology and Prevention—Greeley *26
Abrams, Jerome, Plainfield *110
ACCP Fellows, N. J. 550
Aerosol, Prednisolone, in Dermatology—Fanburg *74
Aged, Bowel Diseases in—Hopping *571
Aged, Council to Improve Care of 329
Aged, Problems of, Symposium 713
Aging, Medical-Surgical Contract for 133
Aging, Problems of—Frank *455
Aiello, Lucy, M.T., New Brunswick *34
Alcoholic Executives ab116
Alcoholic, Hypnosis of ab321
Allergy, Fundamentals of (Edited by S. J. Prigal) br727
Allergy, One Shot "Cure" e290
AMA Delegates, List of (Advertising page 3A each issue of THE JOURNAL)
—Report of 661
Amato, R. J., Letter from 278
Analysis, Direct (M. W. Brody) br285
Anatomy, Gray's (Edited by C. M. Goss) br162
Anesthesia Coverage in Obstetrical Service—Potekhen *634
Anesthesia for Cystoscopies—Karfopoulos *576
Anesthesia for Infants and Children (R. M. Smith) br104
Angiomyolipoma—White and deVries *528
Announcements 48, 99, 155, 176, 177, 280, 552, 608, 666, 722
Annual Meeting, 193rd—
Medical Care Symposium 135
Presentation of Presidential Plaques and Certificates 91
Speakers' Section of Banquet 148
Annual Meeting, 194th—
General Session 712
Offices to be Filled by Election 129
Official Attendance 351
Program 185
Scientific Exhibit Award 351
Transactions 356
Antidepressive Agent, Trial of—Landman *322
Antimalarials in Dermatomyositis—Ward *317
Arenas, Catalino, Trenton *469
Armed Forces Need for Physicians 280
Arthritic Diseases, Treatment of—Denson and Thompson *314
Arthritis Booklet Available 599
Arthritis Medical Treatment and Home Care (J. H. Bland) br555
Arthritis, Treatment of—Tillis *485
Aspiration of Thoracic Cavity—Nitshe *653
Athletic Activities, School 112
Atkins, J. P., Philadelphia, Pa. *23
Atlantic County Medical Society 50, 100, 156, 181, 222, 505, 723
Audio-Frequency Generator—Hall *465
Auerbach, Frederick† 153
Auscultation of the Heart (Levine and Harvey) br161
Automobile Decals 42
Aviation Medical Examiners 550
Axilrod, Herbert D., Atlantic City *584
Ayd, Frank J., Jr., Baltimore, Md. *4
Aygen, M., Jersey City *69

B

Babies by Choice or by Chance (A. F. Gutmacher) br509
Back Pain (J. M. Mennell) br727
Bacon, Mary, Honor for 500
Baldwin, John F.† 43
Balter, Abraham M., Lyons *479
Barlow, G. Barton, Englewood *695
Barnett, Robert, Asbury Park *547
Belfer, Jacob J.† 178
Bergen County Medical Society 50, 156, 223, 281, 334, 506, 607, 723
Biber, David, Letter from 503
Bladder, Rupture of—Axilrod *584
Blaisdell, C. Byron, Asbury Park *715
Blecher, Irving E., Lyons *479
Blood Volume and Protein Diet—Arenas and Ryan *469
Bloom, Herbert, Trenton *170
Blue Cross-Blue Shield Riders 346, 660
Blue Cross Study Committee 347
Blue Shield, Long View e236
Bokor, Emery† 354
Bolivia, Doctor in (E. Mautner) br671
Book Reviews 53, 103, 161, 179, 284, 340, 507, 554, 609, 670, 727
Books for Use Abroad 553
Bowel Biopsy—Friedman *658
Bowel Diseases in Older People—Hopping *571
Bowen's Disease ab244
Brain Tumor, Psychiatric Symptoms in—Sandler *471
Breast Cancer (Edited by A. Segaloff) br162
Brown, Charles L.† 43
Burlington County Medical Society 50, 157, 224, 281, 335
Burrill, Benjamin B., Montclair *623
Bush, Mrs. Ralph K. 339

C

Calculi of Ureters, Management of—Lerman and Lerman *78
Camden County Medical Society 181, 667
Cancer in Families (Murphy and Abbey) br286
Cancer Morbidity br54
Cancer, When a Family Faces (E. Ogg) br509

1- 56—Jan.
57-106—Feb.
107-164—March
165-234—April
235-288—May
289-344—June
345-448—July
449-510—Aug.
511-558—Sept.
559-612—Oct.
613-674—Nov.
675-738—Dec.

Cancer: Worldwide Menace br510
Carcinoma (See organ affected)
Cardiac Arrest and Resuscitation (H. E. Stephenson, Jr.) br103
Carlough, David J.† 277
Carotid Body Tumor—Hardy *544
Carrier, Russell N., Belle Mead *124
Cartisser, Joseph J.† 599
Cause for Worry e1
Celeste Francis, Sister, O.S.F., Trenton *168
Cerebrospinal Fluid Protein—Winter and Ross *252
Cerone, Daniel M., Newark *65
Chest Density Due to Skin Tumor—Gelvin *684
Chiropodists, MSP Payment to 40
Cholinesterases (A. Gerebtzoff) br672
Christmas Seals e615
Cigarette Habit (A. King) br609
Cigarette Smoking and Lung Cancer—Finkelstein *616
Civic Service by M.D.s e614
Civil Defense 661
Civil Defense Items 47
Civil Defense, Medical—Karel *84
Civil War Descendants 552
Cluster Testing—Dougherty and Hammond *517
Coffee as a Food Allergen—Green *307
Committee Chairmen, List of (Advertising page 3A)
Committees, List of (Advertising page 4A, April and August issues)
Communications Breakdown e235
Condouris, G., Ph.D., Jersey City *69
Constipation, Psychosomatic Factors—Lewis *654
Constitutional Amendments, Proposed 36
Conty, Anthony J.† 599
Cooper, Jules, Woodbine *20
Coronary Artery Disease—Gordon *et al.* *677
Cosgrove, Samuel† 178
Costello, William, Honor for 504, 662
Coultas, Aldo B.† 711
County Society Presidents and Secretaries 52
—(Also Advertising page 6A, April and August issues)
Crounse, David R.† 277
Cumberland County Medical Society 51, 158, 226, 335, 506, 667
Current Medical References (Edited by P. J. Sanazaro) br340
Current Therapy: 1959 (Edited by H. F. Conn) br53
Cystoscopies, Anesthesia for—Karfopoulos *576

D

Davidson, Harold S.† 153
Davis, Louis† 551
Davis, William A., Glen Ridge *20
Degree Nursing ab128
Delegates, House of, Special Meeting 346
De Magnete (W. Gilbert) br555
Denholtz, Emanuel† 43
Denson, L. J., Hackensack *314
Dental Services, Prepayment of 706, 707
Depression in Middle-Aged Patients—Whitaker *636
Depressions, Evaluation of ab241
Depressions, Pharmacologic or Electrical Therapy?—Furst *113
Deprol, Clinical Trial of—Landman *322
Dermatology, Practical (G. M. Lewis) br54
Dermatology, Recent Advances in—Burrill *623
Dermatomyositis, Antimalarials in—Ward *317
DeSpirito, Anthony, Asbury Park *547
deVries, John K., Summit *528
Dexamethasone in Ophthalmology—Harley and Mishler *173
Diabetes Detection Week e559
Diabetes, Impotence and—Tushnet *256
Diabetes of the Poor ab496
Diabetes, Skin Testing for ab626
Diabetes, Tolbutamide Treatment of—Oyer *117
Diabetic Cook Book (M. Behrman) br179
Diet Manual 470
Digestive Tract, Upper (F. H. Netter) br180
Diplegia, Congenital ab652
Diuretics in Congestive Heart Failure—Schwartz, *et al.* *69
Doctor as a Scapegoat e290
Doctors' Nurses Association 280
Documentary Film Available ab685
Dougherty, William J., Trenton *237, *517
Drug Addiction ab459
Drug Promotion, Financing e236
Drugs for Mental Patients 325
Drugs of Choice (Edited by W. Modell) br609

E

Ear, Nose and Throat Diseases (Ryan, Tornell and Von Leden) br508
Eck, Daniel B., East Orange *300
Eckstein, David, Trenton *719
Edelson, Edmond, Newark *566
Edema (Edited by Moyer and Fuchs) br672
Ehrlich, Albert, Hoboken *642
Electric Brains e166
Electrical Therapy in Depressions—Furst *113
Electrocardiogram, Differential Diagnosis of (Arbeit, Rubin and Gross) br727
Encephalitis, Reporting of 501
Enuresis ab310
Ephebiatrics e3
Ewen, Warren L., Centenary for 549
Executive Health e561
Eye Care for School Children 268
Eye Care, Payment of 499
Eye, Physiology of (F. H. Adler) br284
Eye Surgery, Complications of (Edited by R. M. Fasanella) br162

F

FACS in New Jersey 665
Fall-Out, Medical Effects of 134
Family Medical Encyclopedia (J. J. Schifferes) br180

---

* Original article
† Obituary
ab—Abstract
e—Editorial

br—Book Review
Annual Reports: July JOURNAL
Transactions: July JOURNAL

Family Physician as Psychotherapist—Gordon *292
Fanburg, Sol J., Newark *74
Farley, William J., Nutley *700
Farr, Walter J.† 102
F.B.I. Wants Cardiac Patient 665
Fedor, John A.† 599
Fellow's Key, Presentation of 150
Fertility Determination by Test Papers 49
Finkelstein, Max, Jersey City *616
First Aid Diagnosis and Management (Cole and Puestow) br672
Fish to Philosopher (H. W. Smith) br556
Fisher, Samuel, Paterson *489
Flexion-Extension Injuries of the Spine—Eck *300
Fracture Surgery (Milch and Milch) br342
Fractures and Dislocations (A. F. DePalma) br509
Frank, Ulysses M., Millburn *455
Franks, Cyril M., Ph.D., Belle Mead *124
Fraternal Orders and Medical Care e512
Friedenberg, Sidney, Camden *32, 154
Friedman, Abraham I., Hackensack *658
Front Line of Medicine: Pediatrics—Ruggieri *311
Funded Plan for Eye Care 499
Furst, Nathan J.† 669
Furst, William, East Orange 113
Future Physicians Clubs 709

G

Gallbladder, Rupture of—Kolisch *81
Gallbladder Sinuses—Hall *627
Garber, Robert S., Belle Mead *124, *630
Gardner, Kenneth E. 150
Gelvin, E. P., Whippany *684
General Hospital, Role of Psychiatrist in—Parmet *562
Gere, James B., South Orange *121
Gerendasy, J., Jersey City *258
Geriatric Patient, Care of (E. V. Cowdry) br103
Gilman, C. Malcolm B., Red Bank *491
Glass, Oscar† 354
Gloucester County Medical Society 100, 158, 227, 282, 336, 724
Goldberg, Bernard R., Newark *579
Goldberg, S. A., Newark *250
Goldsboro, Robert F., D.V.M., M.P.H., Succasunna *59
Gordon, Katherine K., B. S., Englewood *677
Gordon, Richard E., Englewood *292, *677
Gordon, Miss Susan Joan, Ventnor *263
Grady, Hugh G., Named Acting Dean 99
Granberry, D. Webb† 669
Granulomatosis, Wegener's—Friedenberg *32, 154
Gray's Anatomy (Edited by C. M. Goss) br162
Greeley, Arthur V., New York, N. Y. *26
Green, Martin, Atlantic City *307
Greenberg, Max† 153
Grindlay, John H., Rochester, Minn *645
Griseofulvin Therapy for Tinea Capitis—Fisher, Lee and Supliki *489
Gynecologic and Obstetric Pathology (E. and E. R. Novak) br161
Gynecology Diplomates 520
Gynecology, Office Diagnosis in—Stella *513

H

Hall, Ralph A., Westfield *465, *627
Halprin, Harry, Montclair *254
Hamartoma, Renal—White and deVries *528
Hammond, Mr. David, Trenton *237, *517
Hardy, G. Robert, New Brunswick *544
Harley, R. D., Atlantic City *173
Hartwell, Henry Ameroy† 178
Hastings, Sir Charles, Biography (W. H. McMenemey) br284
Hausman, Samuel W.† 153
Hawkes, Edward Zeh† e613, 669
Hayden, Walter† 43
Health Careers 661
Health Physics Instrumentation (J. S. Handloser) br556
Healthier Living, Essentials of (J. J. Schifferes) br610
Heart, Auscultation of (Levine and Harvey) br161
Heart Failure, Use of Diuretics—Schwartz *et al.* *69
Heart: Handbook for Laymen (H. M. Marvin) br556
Help-Bringers: Versatile Physicians of New Jersey (F. B. Rogers) br671
Hematology, Fundamentals of (Leavell and Thorup) br670
Hepatitis, Viral (Eichenwald and Mosley) br599
Hindle, F. Lawton† 711
Hitschmann, Otto B., Newark *587
Holderman, Mrs. Beatrice, Trenton *170
Holmes, Sherlock, A Doctor Enjoys (E. Van Liere) br671
Hudson County Medical Society 51, 100, 158, 181, 336, 667, 724
Hunter, John, Biography of (J. Kobler) br510
Huss, Louis† 711
Hutcheon, D. E., Jersey City *69
Hydrochlorothiazide, Hyperglycemic Reaction to—Halprin *254
Hyperbilirubinemia in the Newborn—Ehrlich *642
Hypertension, Treatment with Rauwolfia—Barlow *695
Hypertensive Disease, First Hahnemann Symposium on (Edited by J. H. Moyer) br342
Hypnosis and Injured Child ab14

I

Impotence and Diabetes—Tushnet *256
Index System, New ab35
Induction Agents for Anesthesia—Riffin *15
Influenza Still a Problem e676
Injuries, Athletic, Prevention and Treatment of—Farley *700
Intracardiac Study, Pioneer Contributions to—Aiello *34
Irmisch, George W., Trenton *689

1-56—Jan.
57-106—Feb.
107-164—March
165-234—April
235-288—May
289-344—June
345-448—July
449-510—Aug.
511-558—Sept.
559-612—Oct.
613-674—Nov.
675-738—Dec

J

Jaspan, Samuel C.† 339
Jones, Helen E., Asbury Park *547
Jordan, Kenneth,† Montclair 44, *475
Joseph, Benjamin† 178
Judicial Council, Records of 664
Judicial Councilors, List of (Advertising page 3A, each issue of THE JOURNAL)

K

Karel, Jack R., Elizabeth *84
Karfopoulos, Alexander, Bayonne *576
Katz, Herbert† 277
Keith, Theodore R., Passaic *533
Kidde, Mr. Walter L. 141
Kidney, Injury of—Irmisch *689
Knapp, Richard E.† 178
Knee Joint, Sprains and Strains—Kuhn *686
Kolisch, Paul DeR., Phillipsburg *81
Kornfeld, Werner, East Orange *649
Kraemer, Samuel H.† 102
Kuhn, William G., Jr., New Brunswick *686

L

Laboratory Animals, Shipment of e345
LaFace, Annunziato† 551
Landman, Milton E., Bloomfield *322
Lapin, L. P., Bordentown *5[illegible]0
Law and the Physician (R. H. Long) br180
Lee, Frederick E., Paterson *489
Legal Environment of Medical Science br340
Legislation, Council on 662
Lehmacher, Frank† 44
Lerman, Fred, Elizabeth *78
Lerman, Irving, Elizabeth *78
Letters to THE JOURNAL 278, 503
Leukemia in Monmouth County—Jones, Barnett and DeSpirito *547
Levy, Herman, Passaic *242
Lewis, Sanford M., Newark *654
Liability Insurance for Administrative Physicians 257
Liability Insurance for Government Employees 710
Lieberman, David P.† 354
Lowrey, James H.† 551
Lung Cancer and Cigarette Smoking—Finkelstein *616
Luongo, Gene† 44
Lynch, Donald C.† 711

M

Magic to Science (C. Singer) br556
Malinowski, John J.† 179
Malpractice Insurance 497
Mann, Jacob J.† 669
Marin, Robert B. 278, e561
Mastectomy, Simple ab260
Maturi, Vincenzo E.† 102
McCall, Jesse, Newton 135, e289, *452
McCarron, James A.† 551
McWhorter, John E., Englewood *677
Medical Index System ab35
Medical Sales Representatives Play Santa Claus 160
Medical Student Loan Fund 709
Medical-Surgical Plan Discussion 600
Medical-Surgical Plan Fee Apportionment 707
Medical-Surgical Plan Public Relations Counsel 706
Medical-Surgical Plan Rates of Payment 346
Medicare, Amended Contract 709
Medicare Laboratory Work 279
Medicare, New Contract 88
Medicare Payments 549
Medicare Program 131, 134
Medicare Supplement 327
Medieval and Renaissance Medicine (B. L. Gordon) br610
Meehan, George† 277
Megacolon, Congenital ab244
Melanomas—Goldberg *250
Membership Directory, Supplementary Lists 45, 273, 331, 352, 502
Meningitis, Pneumococic, Treatment of—Balter and Blecher *479
Mental Deficiency, State Division of 266
Mental Retardation Division 593
Mental Subnormality (Masland, Sarason and Gladwin) br508
Meprobamate Overdosage ab578
Meprobamate Relieving Syncope—Cooper and Davis *20
Mercer County Medical Society 51, 101, 159, 182, 282, 336, 353
Microbiologic Reactions (Edited by Wolstenholme and O'Connor) br179
Middlesex County Medical Society 52, 101, 159, 182, 227, 282, 336, 353, 554, 724
Military, Medical, History Available 721
Military Surgery in the American Revolution—Gilman *491
Minor Surgery, Christopher's (Edited by Ochsner and DeBakey) br342
Mishler, J. E., Atlantic City *173
Mitral Insufficiency, Surgery for—Morse, Ramundo and Keith *533
M'Naughten Rule, Resolution 593
Mobile Operating Room ab575
Modarress, Y., Trenton *168
Monmouth County, Leukemia in—Jones, Barnett and DeSpirito *547
Monmouth County Medical Society 159, 183, 228, 337, 353, 668, 725
Morris County Medical Society 228, 725
Morse, Dryden P., Passaic *533
Mosquitoes, Important (Foote and Cook) br508
Mott, Joseph E.† 355
Moving Picture Summaries Available 454
Muscle Spasm, Relief of—Jordan *475

---

* Original article
† Obituary
ab—Abstract
e—Editorial

br—Book Review
Annual Reports: July JOURNAL
Transactions: July JOURNAL

N

Neal, Mr. Robert R. . . . 138
Nelson, Harry† . . . 154
Nephrotic Syndrome . . . ab694
Neurology, History of (W. Riese) . . . br54
Nevin, Richard L., Trenton . . . *713
New and Nonofficial Drugs, 1960 . . . br610
Newborn, Hyperbilirubinemia in—Ehrlich . . . *642
Nitshe, G. A., Jr., Monroeville . . . *653
"Normal," Concept of . . . e675
Novocaine Research (A. Aslan) . . . br280
NTA Abstracts . . . 55, 105, 163, 233, 287, 348, 557, 611, 673, 737
Nursing by Degrees . . . ab128
Nursing Curriculum . . . 325
Nutrition, Modern (Edited by Wohl and Goodhart) . . . br510
Nutrition Speakers Available . . . ab64
Nylon in Hernia Repair . . . ab313

O

Obituaries . . . 43, 102, 153, 178, 277, 339, 354, 551, 599, 669, 711
Obstetrical Double "Set-up" in Operating Room—Salzmann . . . *531
Obstetrical Service, Anesthesia Coverage—Potekhen . . . *634
Obstetrics and Gynecology, N. J. Diplomates 520
Obstetrics, Third Degree Tears—Levy . . . *242
Occupational Therapy (W. L. West) . . . br53
Officers, List of (Advertising page 3A, each issue of THE JOURNAL)
Ophthalmology, Dexamethasone in—Harley and Mishler . . . *173
Ophthalmology, Synopsis of (W. H. Havener) br508
Opiferque . . . e449
Oral Poliomyelitis Vaccine . . . ab532
Orr, Louis M. . . . 93, 152
Orthopedic Instructional Course . . . br285
Otolaryngology, Textbook of (DeWeese and Saunders) . . . br555
Out of the Rut . . . e560
Oyer, Calvin E., Kearny . . . *117

P

Pain and Itch (Edited by Wolstenholme and O'Connor) . . . br507
Pain, Orthopedic, Relief of—Jordan . . . *475
Pannullo, John N., Newark . . . *65
Parkinsonism, Surgery for . . . ab648
Parmet, Morris, Flemington . . . *562
Parotitis, Post-Operative—Spiro . . . *261
Passaic County Medical Society . . . 52, 101, 159, 184, 229, 283, 338, 353, 725
Pathology, General (Edited by H. Florey) . . . br103
Pathophysiology in Surgery (J. D. Hardy) . . . br161
Payola, Political (Letter) . . . 278
Pediatrics, Front Line of Medicine—Ruggieri *311
Pellegrino, Edmund D., Flemington . . . *59
Persistin in Arthritic Diseases—Denson and Thompson . . . *314
Petrone, Peter A.† . . . 551
Petryshyn, Walter A., Flemington . . . *521
Pharmacologic Therapy in Depressions—Furst *113
Physical Diagnosis (Prior and Silberstein) . . . br286
Physician and the Law (R. H. Long) . . . br180
Physician Increase in New Jersey . . . ab641
Poison Control Centers . . . 48
Poisoning, Handbook of (R. H. Dreisbach) . . . br510
Poisons, Unlabeled . . . e291
Polio Vaccine . . . ab249
Potekhen, George P., Plainfield . . . *634
Pre-anesthetic Medication—Vlatten . . . *692
Prednisolone in Dermatology—Fanburg . . . *74
Prednisolone in Treatment of Arthritis—Tillis *485
Prepayment, Medical, and Philosophy . . . e450
Presidential Plaques and Certificates, Presentation of . . . 91
President's (Bowers) Address . . . 447
Proctologist on Maternity Service—Gerendasy *258
Professional Liability . . . 497
Profile in Mirror . . . e57
Promethazine Anesthesia in Pediatric Patients—Vlatten . . . *692
Promethazine in Obstetrics—Pannullo and Cerone . . . *65
Protein Diet, Effect on Blood Volume—Arenas and Ryan . . . *469
Pseudo-Retardation—Goldberg . . . *579
Psychiatric Abstracting Service—Carrier, Garber and Franks . . . *124
Psychiatric Hospital, Private—Garber . . . *630
Psychiatric Research, Control in . . . br341
Psychiatric Symptoms in Brain Tumors—Sandler . . . *471
Psychiatrist, Role of, in General Hospital—Parmet . . . *562
Psychoneuroses in Medical Practice—Rowen . . . *460
Psychosomatic Factors in Constipation—Lewis *654
Psychotherapy by Family Physician—Gordon *292
Publication Committee Vacancy Filled . . . 595
Public Health, Council on . . . 329
Public Relations, Council on . . . 333

Q

Q-Fever in New Jersey—Pellegrino, Goldsboro, and Sussman . . . *59

R

Radiation Dangers, Exaggerated . . . ab33
Radioactivity in Food . . . ab251
Radio-isotope Studies of Fatty Acids (Mead and Howton) . . . br672
Radiology, Therapeutic (W. T. Moss) . . . br284
Ramundo, Michael, Passaic . . . *533
Rauwolfia Treatment of Hypertension—Barlow . . . *695

1- 56—Jan.
57-106—Feb.
107-164—March
165-234—April
235-288—May
289-344—June
345-448—July
449-510—Aug.
511-558—Sept.
559-612—Oct.
613-674—Nov.
675-738—Dec.

Read, Hilton, Citations for 267
Regularity, Myth of ab694
Rehabilitation and the Private Practitioner e166, *170
Rehabilitation Commission Offices 169
Rehabilitation, Doctor's Third Arm—Bloom and Holderman *170
Reluctant Surgeon (J. Kobler) br510
Renal Injury—Irmisch *689
Research, Significant Trends in (Edited by G. E. W. Wolstenholme) br610
Research, Surgical, in 1960—Grindlay *645
Respiratory Physiology (J. H. Knowles) br341
Responsible Means Answerable e511
Resuscitation and Cardiac Arrest (H. E. Stephenson, Jr.) br103
Retardation, Developmental Aspects of—Kornfeld *649
Retardation Masking Schizophrenia—Goldberg *579
Retarded, Community Clinic for—Stone *540
Rheumatic Disease Bulletin 280
Rhinitis, Infectious Versus Allergic—Petryshyn *521
Riffin, Irving M., Upper Montclair *15
Rita, James J.† 669
Roentgenographic Positions, Atlas of (V. Merrill) br340
Rogers, Lawrence H., Resolution on 98
Rokitansky-Aschoff Sinus—Hall *627
Rosen, Charles E.† 154
Rosen, Frank, on Publication Committee 595
Ross, George, B. S., East Orange *252
Rowen, M. J., Elizabeth *460
Roy, Bert W.† 44
Ruggieri, Bartholomew A., Montclair *311
Rundlett, Emilie V.† 44
Ryan, R. J., Trenton *168, *469

S

"Sack-'Em Up" Boys—Gordon *263
Salem County Medical Society 102, 160, 184, 230, 283, 338, 668, 726
Salzman, Nathan† 277
Salzmann, Bertold, Linden *531
Sandler, Samuel A., Hackensack *471
Scanlan, D. Ward† 670
Schaaf, Royal A. 136
School Athletic Activities 112
School Children, Examination of 350
School Children, Eye Care for 268
Schwartz, M. L., Jersey City *69
Schwartz, Samuel H.† 355
Science and Art of Medicine—McCall *452
Scruples, No More e2
Senior Citizens Center 349
Serology Report Forms 553
Seton Hall, Naming of Acting Dean 99
Shannon, Anne Lardner† 355
Shapiro, Nathaniel J.† 339
Sheiner, Ben, Westwood *525
Shulman, Abraham† 44
Sickling and Pregnancy—Abrams *110
Silicon Skin Disease ab260
Singer, Marcia G., M.A., Englewood *677
Sinkinson, Charles D.† 670
Sinusitis, Infectious Versus Allergic—Petryshyn *521
Skin Diseases, Diagnosis in—Hitschmann *587
Skin Diseases, Manual of (G. C. Sauer) br286
Skin Tumor—Gelvin *684
Small Intestine, Tumors of—Ward and Gere *121
Smith, A. Marshall, Jr., New Brunswick *245
Smoking and Health (J. Messner) br340
Smugness, Sepsis and Syphilis e109
Society for the Relief of Widows and Orphans, Financial Statement 464
Sommer, George N. J.† e451, 503
Sophocles, A. M., Trenton *23
South African Medical Directory 279
Speakers Available on Nutrition ab64
Specialization, Air of (Letter) 278
Spevack, Max† 179
Spiro, Robert K., Bloomfield *261
Sprains and Strains of Knee Joint—Kuhn *686
Staphylococcus Control—Modarress, Ryan and Sister Celeste Francis *168
Stella, Joseph G., Atlantic City *513
Steroid Therapy with Ruptured Gallbladder—Kolisch *81
Stone, Nellie D., M. S. W., East Orange *540
Student Quality, Is It Falling? e108
Suburbs, Heart Disease in—Gordon *et al.* *677
Supliki, Dorothy, R. N., Paterson *489
Surgeon and the Child (W. J. Potts) br104
Surgery, Minor, Christopher's (Edited by Ochsner and DeBakey) br342
Surgery, Synopsis of (C. Wakeley) br53
Surgery, Textbook of (Edited by H. F. Moseley) br53
Surgery, Triumph of (J. Thorwald) br555
Surgical Patient, Metabolic Care of (F. D. Moore) br341
Surgical Research in 1960—Grindlay *645
Sussman, Oscar, D.V.M., M.P.H., Trenton *59
Syncope, Relieved by Meprobamate—Cooper and Davis *20
Syphilis Resurgence—Dougherty and Hammond *237
Syphilis, Testing for—Dougherty and Hammond *517
Syphilis Today—Edelson *566

T

Tataryan, Hovsep† 154
Team Physician, Role of—Farley *700
Teen-Age Years (A. Roth) br609
That the Patient May Know (H. F. Dowling) br162
Therapeutic Radiology (W. T. Moss) br284
Thomas, George N.† 102
Thompson, W. R., Hackensack *314
Thoracic Cavity, Aspiration of—Nitshe *653
Thyroid Crisis—Smith *245

* Original article
† Obituary
ab—Abstract
e—Editorial

br—Book Review
Annual Reports: July JOURNAL
Transactions: July JOURNAL

Tillinghast, Mr. Carlton W. 143
Tillis, Herman H., Newark *485
Tin Can, Salute to e58
Tinea Capitis, Therapy of—Fisher, Lee and Supliki *489
Tolbutamide in Diabetes—Oyer *117
Toy, Calvert R.† 154
Tracheotomy, Scope of—Sophocles and Atkins *23
Tranquilizers, Current Status—Ayd *4
Travel Health Regulations 176
Traveler's Guide to Good Health (C. Rule) br671
Trifluopromazine by Drip Method—Sheiner *525
Trustees, Board of, Meetings—
November 15, 1959 37
December 20, 1959 87
January 17, 1960 130
February 21, 1960 266
March 20, 1960 325
April 24, 1960 346
May 13, 1960 497
May 17, 1960 497
June 26, 1960 593
August 21, 1960 660
September 18, 1960 706
Tuberculosis, Eradication of 503
Tuberculosis Today 89
Tunis, Benno B.† 551
Tushnet, Leonard, Irvington *256
Twins and Mental Illness ab648

U

Ulcer of Stomach ab253
Union County Medical Society 230, 507
Unlabeled Poisons e291
Ureteral Calculi, Management of—Lerman and Lerman *78
Urethra, Rupture of—Axilrod *584
Uroscopy, Fall and Rise e450

V

Vanishing Elixir e165
Vann, Dorothea D., Art Award to 504
Virus, Virulence and Pathogenicity br554
Vlatten, R. A., Newark *692

W

Ward, R. Wendell, South Orange *121, *317
Warren County Medical Society 232
Washburn, William deV., Baltimore, Md. *717
Weber, Walter D.† 277
Wegener's Granulomatosis—Friedenberg *32, 154
Weight Loss, Long-Term—Lapin *590
Weinmann, Max H.† 179
Weiss, Morris J.† 355
Which Path to Medical Security? e107
Whiplash Injuries—Eck *300
Whipping Boy, Blue Shield as e560
Whitaker, John C., Riverton *636
White House Conference on Aging 38, 130
White, Robert R., III, Summit *528
Willis, Benedict P.† 154
Winter, Arthur, East Orange *252
Woman's Auxiliary President 339
Woman's Auxiliary Program 597, 708

Y

Yawning as Exercise ab488
Young, George J.† 670

1- 56—Jan.
57-106—Feb.
107-164—March
165-234—April
235-288—May
289-344—June
345-448—July
449-510—Aug.
511-558—Sept.
559-612—Oct.
613-674—Nov.
675-738—Dec.

ABSTRACTS

on Tuberculosis and Other Respiratory Diseases. Issued by the National Tuberculosis Association

DECEMBER, 1960 • VOL. XXXIII, NO. 10

THE PRICE OF TUBERCULOSIS CONTROL

Control of tuberculosis is now within our grasp if it is regarded as important enough by leaders in public health. Prevention of infection, treatment of the infected individual, will accomplish it.

Despite substantial advances in diagnosis and therapy of tuberculosis as a disease, the basic problems of tuberculosis control have remained relatively unchanged over the years. The magnitude of the problem of control has changed, but its nature is the same. Prevention of infection with its consequent disease and death is still the goal in the United States, and no short cuts to this goal have been discovered. The old road of isolation of the infected, plus treatment and education of the patient and his contacts to minimize the spread of infection is still the highway to the elimination of tuberculosis as a public health problem.

NEW INFECTIONS STILL OCCUR

There is good evidence that new infections in the United States have been substantially reduced in number and in rate. There is equally good evidence that new infections still occur in most parts of the country. There is even evidence that the areas where the greatest number and rate of new infections is greatest can be predicted. At the moment infection takes place, the continuance of this preventable, communicable and chronic disease is assured.

What seems worth wondering about is why there is so little concern about this situation. Do we reserve all our moral indignation about the resigned or callous attitudes toward disease and death for far-away places that we can designate as underdeveloped? What are the things we value more highly than the prevention of a disabling and deadly disease we know to be preventable? These, of course, are slanted questions.

Actually, it does not seem appropriate for official agencies and voluntary associations paid by the public to control tuberculosis to take a detached attitude in this matter. Can such agencies be satisfied with anything less than complete control? Why this indecision?

AREAS OF INDECISION

Some points of indecision about tuberculosis control are easily discernible:

1. The belief that although tuberculosis is a communicable disease, it is not so communicable that isolation of all cases is deemed a necessity. The risk of the spread of tuberculosis is more tolerable than infringement of individual liberty.
2. The belief that the interests of the practicing physician are paramount to the public's interest in tuberculosis control. How many health departments can count upon regular verification that the public interest has been served in connection with cases under the supervision of private physicians?
3. The belief that the effort required for keeping track of the patient as he moves from suspect to diagnosed case and from one form of treatment to another isn't worth the effort.
4. The belief that the cost of tuberculosis control should be borne by the patient if at all possible.

Donald A. Trauger, Division of Research & Statistics, June 29th, 1960.

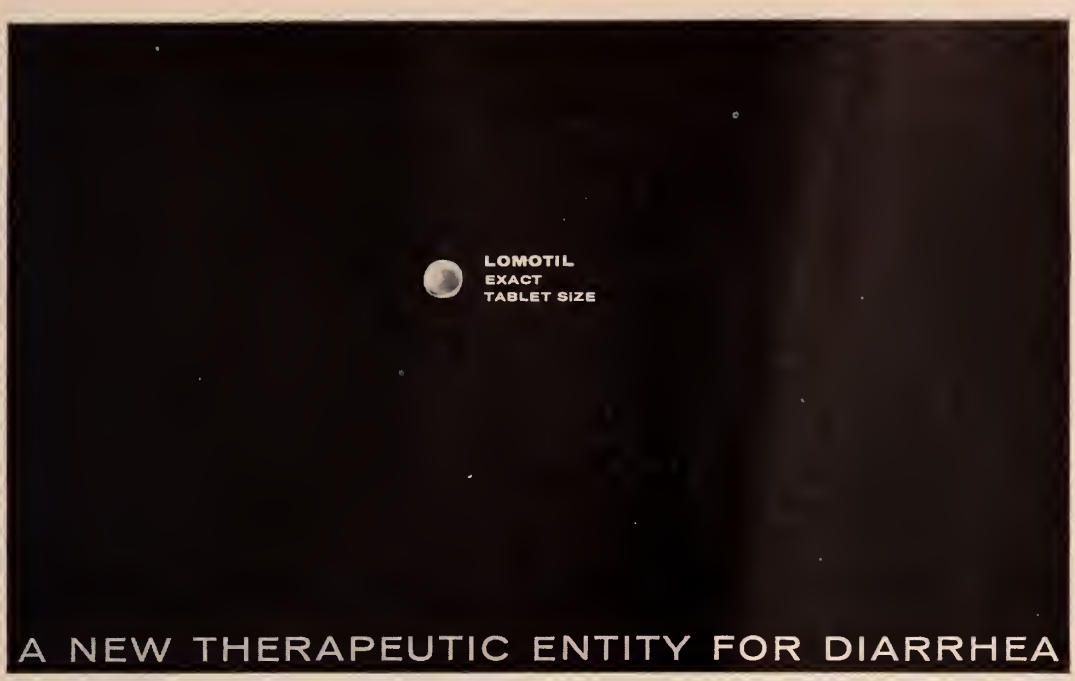
5. The belief that tuberculosis needs to be controlled only in persons with legal residence of various public health jurisdictions.
6. The belief that care (or neglect) of tuberculosis is cheaper than tuberculosis control.
7. The belief that control is undemocratic, inhuman and unneeded.
8. The belief that patients must accept hospital treatment or be dismissed from health department concern.

These are a few of the most common points of indecision about tuberculosis control. Undoubtedly, many people are infected each year by people who do not know they have tuberculosis in a communicable stage, others are infected by people whose doctors know they have tuberculosis but the health department does not, and still others are infected by persons who have been reported to the health department as tuberculous. When infection results in the last two types of situations, the health department or the medical profession has failed. If we believe in health department control of tuberculosis, each case of medical profession failure is also a case of health department failure. When infections result from exposure by a person who does not know he has tuberculosis, it is appropriate to ask why he did not know. If he was ever known to the health department or a physician as a case or as a suspect or as a contact, can we claim infection was unavoidable?

ELIMINATION OF TUBERCULOSIS POSSIBLE

Experts now believe we could eliminate tuberculosis, not by waiting for it to burn itself out but by the use of widespread chemotherapy as a public health measure. They believe this prospect of elimination may wane if not pursued promptly and vigorously. The challenge is whether we can accomplish this without more control and without coming to decisions about matters which have impeded control in the past. Briefly, it comes to this—tuberculosis can be controlled if it is regarded by leaders in the field of public health as important enough. In a specialized society preoccupied with many other concerns, vigorous leadership is required. Leadership which waits for a clear, clarion demand for action from the man in the street simply isn't leadership these days and accomplishes little. Public health leaders must lead.

NEW JERSEY TRUDEAU SOCIETY
is the medical section of
NEW JERSEY TUBERCULOSIS AND HEALTH ASSOCIATION
15 EAST KINNEY STREET, NEWARK 2, NEW JERSEY



A NEW THERAPEUTIC ENTITY FOR DIARRHEA

LOMOTIL®

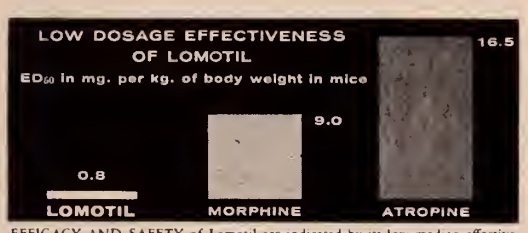
SELECTIVELY LOWERS PROPULSIVE MOTILITY

LOMOTIL represents a major advance over the opium derivatives in controlling the propulsive hypermotility occurring in diarrhea.

Precise quantitative pharmacologic studies demonstrate that Lomotil controls intestinal propulsion in approximately 1/11 the dosage of morphine and 1/20 the dosage of atropine and that therapeutic doses of Lomotil produce few or none of the diffuse untoward effects of these agents.

Clinical experience in 1,314 patients amply supports these findings. Even in such a severe test of antidiarrheal effectiveness as the colonic hyperactivity in patients with colectomy, Lomotil is effective in significantly slowing the fecal stream.

Whenever a paregoric-like action is indicated, Lomotil now offers positive antidiarrheal control ... with safety and greater convenience. In addition, as a nonrefillable prescription product, Lomotil offers the physician full control of his patients' medication.



EFFICACY AND SAFETY of Lomotil are indicated by its low median effective dose. As measured by inhibition of charcoal propulsion in mice, Lomotil was effective in about 1/11 the dosage of morphine hydrochloride and in about 1/20 the dosage of atropine sulfate.

PRECAUTION: While it is necessary to classify Lomotil as a narcotic, no instance of addiction has been encountered in patients taking therapeutic doses. The abuse liability of Lomotil is comparable with that of codeine. Patients have taken therapeutic doses of Lomotil daily for as long as 300 days without showing withdrawal symptoms, even when challenged with nalorphine.

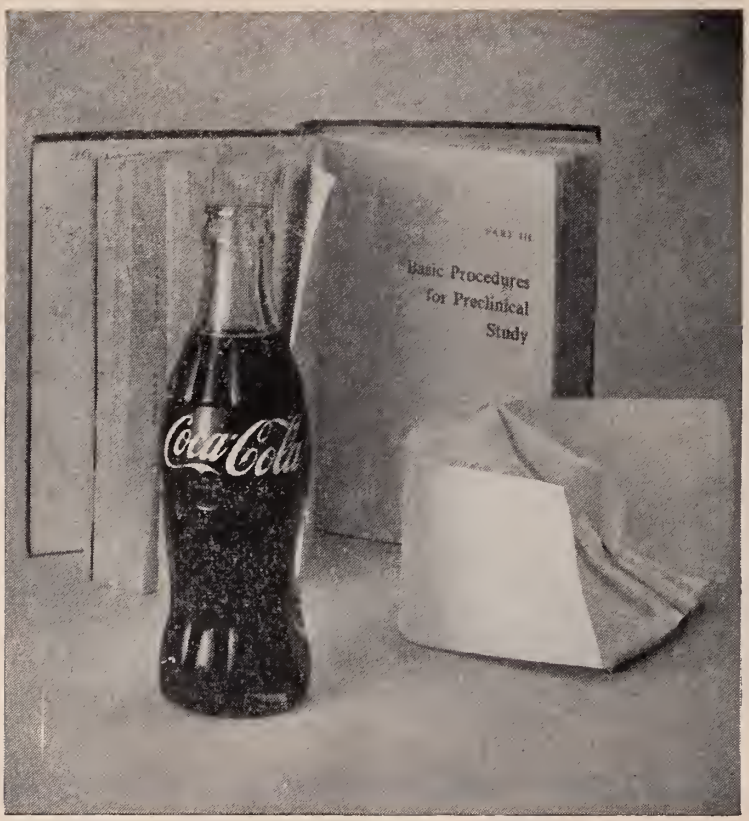
Recommended dosages should not be exceeded.

DOSAGE: The recommended initial dosage for adults is two tablets (5 mg.) three or four times daily, reduced to meet the requirements of each patient as soon as the diarrhea is controlled. Maintenance dosage may be as low as two tablets daily. Lomotil, brand of diphenoxylate hydrochloride with atropine sulfate, is supplied as unscored, uncoated white tablets of 2.5 mg., each containing 0.025 mg. (1/2400 gr.) of atropine sulfate to discourage deliberate overdosage.

Subject to Federal Narcotic Law.

Descriptive literature and directions for use available in Physicians' New Product Brochure No. 81 from

G. D. SEARLE & CO.
P.O. Box 5110, Chicago 80, Illinois
Research in the Service of Medicine



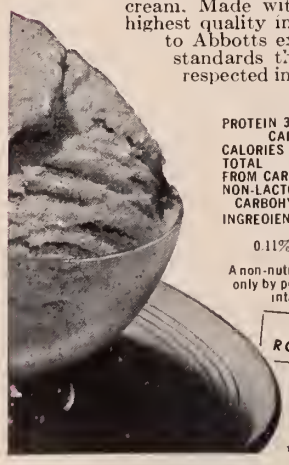
When too many tasks
seem to crowd
the unyielding hours,
a welcome
"pause that refreshes"
with ice-cold Coca-Cola
often puts things
into manageable order.

DRINK
Coca-Cola
REG. U.S. PAT. OFF.

NOW! DIABETICS CAN ENJOY
(UNDER MEDICAL ADVICE)

Abbotts
ARTIFICIALLY SWEETENED
ICE CREAM

Your patients whose sugar intake is restricted will relish the extra delicious flavor of Abbotts new, sugar-free ice cream. Made with infinite care and highest quality ingredients according to Abbotts exacting standards—standards that are most highly respected in the dairy industry.



COMPOSITION
PROTEIN 3.52% MILK FAT 10.52%
CARBOHYORATES 21.35%

CALORIES PER OUNCE	AVOIR.	FLUID
TOTAL	55.02	33.31
FROM CARBOHYORATES	24.21	14.66
NON-LACTOSE CARBOHYDRATES	18.03	10.92

INGREDIENTS: CREAM, MILK, SORBITOL, STABILIZER AND 0.11% CYCLAMATE CALCIUM*

A non-nutritive artificial sweetener for use only by persons who must restrict their intake of ordinary sweets.

IN HANDY ROUND PINTS

At Abbotts
and Jane Logan Dealers
Abbotts Dairies, Inc.

DUGAN'S
"Bakers for the Home"

New - LITE DIET BREAD
(White Bread Baked Without Shortening)
Calories per Slice 42 Calories per oz. 70

ALSO

SALT-FREE BREAD
GLUTEN AND PROTEIN BREADS
100% WHOLE WHEAT
100% Whole Wheat Crackers

New York New Jersey
Connecticut Pennsylvania

"At Your Door or To Your Store,
It's DUGAN'S for BETTER Baked Goods"

Phone for Delivery

HUmboldt 2-6007 in Newark
(or your local phone book for branch nearest you)

After a history and a physical ruled out organic disease, the physician diagnosed the case as recurring states of anxiety. To relieve these symptoms for this busy, on-the-go housewife, he prescribes Meprospan-400, the *only* meprobamate in *sustained-release* form.

As directed, the patient takes one Meprospan-400 capsule at breakfast. Her symptoms of tension and nervousness are soon relieved, and she will not have to remember to take another capsule until dinnertime.

Calm and relaxed, the patient is no longer upset by the pressures and irritations met in everyday life, nor is she likely to be incapacitated by autonomic disturbances, drowsiness, ataxia or other untoward reactions.

Alert and attentive, the patient participates in a P.T.A. meeting, following her second capsule of Meprospan-400 taken with the evening meal. Meprospan-400 does not decrease her mental efficiency or interfere with her normal activities or behavior.

Peacefully asleep, the patient enjoys beneficial rest . . . Meprospan-400 has relieved the tensions that previously prevented sleep or kept her tossing and turning throughout the night.

most widely prescribed tranquilizer . . .
most convenient dosage form . . .

ONE CAPSULE LASTS 12 HOURS

Meprospan®-400

400 mg. MILTOWN® SUSTAINED-RELEASE CAPSULES

Usual dosage: One capsule at breakfast lasts all day, one capsule with evening meal lasts all night. **Supplied:** Meprospan-400, each blue-topped *sustained-release* capsule contains 400 mg. Miltown. **Also available:** Meprospan-200, each yellow-topped *sustained-release* capsule contains 200 mg. Miltown. **For children:** Capsules can be opened and the coated granules mixed with soft foods or liquids.

Both potencies in bottles of 30.

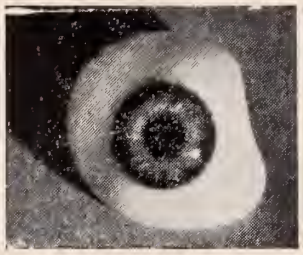
Samples and literature available on request.

WALLACE LABORATORIES / *Cranbury, N. J.*

Specialists in ALL TYPES of Plastic and Glass

ARTIFICIAL HUMAN EYES Exclusively Made to Order in Our Own Laboratory

Doctors Are Invited to Visit



Referred Cases Carefully Attended

AND SATISFACTION GUARANTEED

EYES ALSO FITTED FROM STOCK

PLASTIC OR GLASS SELECTIONS SENT ON MEMORANDUM UPON REQUEST

Implants and Plastic Conformers in Stock

FRIED & KOHLER, INC.

665 FIFTH AVENUE
near 53rd Street

NEW YORK CITY, N. Y.
Tel. ELdorado 5-1970

"Prescribe with Confidence"

KATES BROS.

SCIENTIFIC SHOE FITTING

A Shoe and Last for Every Foot

SOLD ON Rx ONLY
CORRECTIVE FOOTWEAR
FOR MEN - WOMEN - CHILDREN

SOLD ON Rx ONLY
OUTFLAIR SHOES
FOR CLUB FEET

177A JEFFERSON AVE.
PASSAIC, N. J.

69 WESTWOOD AVE.
WESTWOOD, N. J.

202 MAIN ST.
HACKENSACK, N. J.

Dennis Brown Splints — in all sizes — carried in stock

NEW *Antirheumatic Analgesic*

PLANOLAR*

for Rheumatoid Arthritis

Planolar combines the cumulative antirheumatic and anti-inflammatory action of Plaquenil® with the prompt analgesic action of aspirin.

Each tablet contains: Plaquenil 60 mg.
Aspirin 300 mg. (5 grains)

Plaquenil "...the preferred antimalarial drug for treatment of disorders of connective tissue..."[1]

Aspirin belongs to "...the most useful group of drugs for rheumatoid arthritis."[2]

WRITE:
for detailed information (clinical experience, side effects, precautions, etc.)

HOW SUPPLIED: *Bottles of 100 tablets.*

Winthrop LABORATORIES
New York 18, N. Y.

DOSAGE: Adults, 2 tablets two or three times daily. After two or three months of therapy, the patient may no longer need the added benefit of aspirin. A maintenance regimen of Plaquenil sulfate alone (from 200 to 400 mg. daily) may then be substituted.

REFERENCES:

1. Scherbel, A. L.; Schuchter, S. L., and Harrison, J. W.: Cleveland Clin. Quart. 24:98, April, 1957.
2. Waine, Hans: Arthritis, rheumatoid, in Conn, H. F.: Current Therapy 1959, Philadelphia, W. B. Saunders Co., 1959, p. 565.

*Planolar, trademark

ANNUAL CLINICAL CONFERENCE

Chicago Medical Society

FEBRUARY 28, MARCH 1, 2 and 3, 1961

PALMER HOUSE, CHICAGO

Daily Half-Hour Lectures by Outstanding Teachers and Speakers on subjects of interest to both general practitioner and specialist.

Panels on Timely Topics **Teaching Demonstrations**
Medical Color Telecasts **Instructional Courses**

Scientific Exhibits worthy of real study and helpful and time-saving Technical Exhibits.

The Chicago Medical Society Annual Clinical Conference should be a **MUST** on the calendar of every physician. Plan now to attend and make your reservations at the Palmer House.

POST-GRADUATE COURSE
in

CARDIO-PULMONARY DISEASES

Sponsored by

American College of Chest Physicians
New Jersey Chapter

at

HOTEL ESSEX HOUSE, NEWARK, N. J.

MARCH 1, 8, 15 and 22, 1961
1 to 5 P.M.

AAGP CREDIT: 16 Hours FEE: $35.00

For Information Write:

Dr. A. A. Peckman, Chairman
2511 Hudson Boulevard
Jersey City, New Jersey

Protection against loss of income from accident and sickness as well as hospital expense benefits for you and all your eligible dependents.

PHYSICIANS CASUALTY & HEALTH ASSOCIATIONS

OMAHA 31, NEBRASKA

ALL PREMIUMS COME FROM — PHYSICIANS SURGEONS DENTISTS — ALL BENEFITS GO TO

Since 1902
Handsome Professional Appointment Book sent to you FREE upon request.

CLASSIFIED ADVERTISEMENTS

WANTS FOR SALE TO LET

SITUATIONS ETC.

Send replies to box number c/o **The Journal** P. O. Box 904, Trenton 5, N. J.

$3.00 for 25 words or less: additional words 5c each Forms close 15th of the Preceding Month.

GENERAL PRACTITIONER—Well trained, experienced, seeks location or position in the State of New Jersey. Write Box HL, c/o THE JOURNAL.

GENERAL PRACTITIONER wishes to take over established practice, possibly home-office combination. Locum tenens, association or industrial also considered. Reply Box PD, c/o THE JOURNAL.

AVAILABLE GENERAL PRACTITIONER, 36, desires association with experienced practitioner in New Jersey, preferably northeast area, but will consider otherwise. Internal medicine and chest diseases experience. Write Box SF, c/o THE JOURNAL.

OB-GYN—Board eligible, age 31, finishing military service, available June; interested in loose association, group, single practice or partnership. Write Box HR, c/o THE JOURNAL.

GENERAL SURGEON—seeking preceptorship with or without later association with Board-qualified surgeon. Write Box DI, c/o THE JOURNAL.

DOCTORS—2—INTERNAL MEDICINE. Our resident staff consists of retired, New Jersey licensed physicians. If you are thinking of retiring, contact us. Pinehaven Nursing Home & Sanitarium, Inc., Joseph O. Smigel, Executive Director, Pinewald, New Jersey. DIamond 9-2050.

PHYSICIANS interested in neurology for full-time position immediately available in active V.A. Neurologic Center located 40 miles west of Philadelphia. University affiliation. Prefer individuals trained in neurology or internal medicine. Must be U. S. Citizen. Salary scale to $10,635 depending on qualifications, plus 15% for Board certification. Residency in neurology also available. Write John A. Doering, M.D., Manager, Veterans Administration Hospital, Coatesville, Pennsylvania.

ATTRACTIVE, REFINED YOUNG LADY with some knowledge of basic medical procedures wishes to become medical assistant to doctor: vicinity Oranges. Very willing to learn for job with good future. M. Green. RE 1-5496.

HIGH SCHOOL GRADUATE now attending Lyons Institute of Technology. Wishes position as trainee with M.D. Interested in gaining more practical experience. Has basic knowledge. Judy Volk, 29 Lincoln Avenue, West Orange, New Jersey. REdwood 1-1929.

FOR RENT—Five room professional office, fully equipped and furnished. Long established general practice. Fine Bayonne residential area. For information call FEderal 9-5596.

UNUSUAL OPPORTUNITY—Professional Bldg., Montclair, New Jersey. Every advantage. Very low rental. Dr. Mearin—PI 4-5657.

PLAINFIELD, N. J., 1310 West 7th St.—Two suites available, newly built professional building. Wood panelled waiting room, nurses' station, 3 examination rooms one suite, and 2 examination rooms the other suite. Private lavatories, central heating and air conditioning, on site parking. Rent reasonable. Call WAverly 6-3238. One suite now occupied by dentist.

OPHTHALMIC PRACTICE FOR SALE, HACKENSACK, N. J.—20 minutes from New York City. Gross $76,000. Four fully equipped rooms, large reception room, foyer for secretary, all air-conditioned, built-in bookcases and sinks, quiet residential neighborhood opposite park, adequate free parking, rent $175 per month, excellent hospital facilities, growing community, good schools, 400,000 drawing population; reasonable terms. Asking $20,000 for furniture, equipment, practice and lease. Retiring to California. Write Box RN, c/o THE JOURNAL.

(Continued on following page)

CLASSIFIED ADVERTISEMENTS

(Continued from preceding page)

HOME AND OFFICE FOR SALE—Retiring. Good terms, adjoining Newark, 10 miles from New York, large fully equipped office including x-ray; also room for dentist. Air conditioned. Two separate heating units. Elegant living quarters: 28′ living room, 17′ dining room, 3 bedrooms, wall-to-wall carpeting, eat-in kitchen, large expandable attic, full basement, 2-car garage. Contact: Edmund Lewandowski, M.D., 2 Smalley Terrace, Irvington, New Jersey. (population 75,000) ESsex 3-4648.

PERTH AMBOY—Practice for sale due to sudden death of prominent EENT specialist. Established more than 40 years: gross over $60,000.00; same office available; 4 examining rooms; complete modern equipment. Excellent hospital facilities. Replacement urgently needed in rapidly expanding industrial area. Terms of sale open to negotiation. Contact: Alfred D. Antonio, Attorney for Estate, 175 Smith Street, Perth Amboy.

FOR SALE—South Jersey shore area. Will sacrifice home, office, tremendous general practice for real estate value. Leaving for residency. High income assured. Will finance. Write Box FH, c/o THE JOURNAL.

FOR SALE—Two-year old, 6-room equipped office and 7-room house combination of deceased doctor. On Doctors' Row, 5 miles to Geo. Wash. Bridge. Write Mrs. Walter J. Farr, 951 Queen Anne Rd., Teaneck, New Jersey, or phone TE 6-3211.

TENAFLY, N. J.—House and office, separate entrances, corner location, near shopping, buses and schools. Practice optional. Two-story, 8 rooms, 220 volt wiring, air conditioners. $28,500. LOweil 7-0187.

CALIFORNIA

ANNOUNCES

An Eastern Interview Tour

JANUARY 15–29, 1961

for physicians interested in positions with California State Mental Health Programs; starting salaries $12,576 to $14,556.

Representatives, with authority to make definite appointments, will be in Washington, D.C., New York and other cities.

Write for information to:

Medical Personnel Services
STATE PERSONNEL BOARD
801 Capitol Avenue
Sacramento 14, California

PHONE
CH. 2-2330

for well trained highly qualified personnel

MEDICAL
OFFICE ASSISTANTS OR SECRETARIES

Co-Ed (Founded 1936)

N. Y. State Licensed Day-Eve. Courses
Trained by Physicians for Physicians

Eastern

request Free Cat. 7

SCHOOL FOR PHYSICIANS' AIDES
85 Fifth Ave. (16th St.) New York 3, N. Y.
affiliated with CARNEGIE INSTITUTE. INC. *Cleveland, O.*

To train the doctors of tomorrow, medical education needs your help today

Give to the school of your choice through AMEF

AMEF

American Medical Education Foundation
535 N. Dearborn St., Chicago 10, Ill.

FAIR OAKS

SUMMIT, NEW JERSEY

An 80 bed private psychiatric hospital for intensive treatment specializing in the latest therapeutic techniques plus electroshock and insulin coma therapy. Write

THOMAS P. PROUT, Jr.
Administrator

OSCAR ROZETT, M.D.
Medical Director

P. SINGER, M.D.
E. SOKAL, M.D.
ELIZABETH ROZSA, M.D.
M. E. NEUMAN, M.D.
Associates

Tel. CRestview 7-0143

THE ORANGE PUBLISHING CO., Inc.

PRINTERS

116-118 LINCOLN AVENUE

ORANGE, NEW JERSEY

Phone OR 3-0048

The Children's Country Home

An accredited 54-bed specialized hospital for handicapped children. Especially equipped for care of cardiac pre- and postoperative cases, cerebral palsy, polio, congenital defects, rheumatoid arthritis, Legg-Perthes' diseases and other orthopedic conditions. Our services include physical therapy and pool treatments, x-ray, occupational and speech therapy. Regular schooling is provided.

The referring physician may continue to prescribe treatment or may transfer responsibility to our staff.

* * *

New Providence Road
Westfield, New Jersey

For Doctors, Their Patients, and Others Who Prefer Raw Milk . . .

WALKER-GORDON CERTIFIED RAW MILK

In keeping with the Walker-Gordon policy of producing the highest quality Milk possible, and providing it in whatever form the public may request, Certified Raw Milk is made available in many areas through leading milk dealers. Certified Raw Milk is produced in accordance with the highest standards of the American Association of Medical Milk Commissions . . . and more than 60 years of distribution prove it to be *clean—safe—nutritious.* We'll be glad to give you full information on request.

Guaranteed Free of Penicillin

WALKER-GORDON CERTIFIED MILK FARM, *Plainsboro, N. J.* ★ *SWinburne 9-1234*

New York: WAlker 5-7300 ☆ **Phila.: LOcust 7-2665**

Also producers of Certified Pasteurized, Homogenized-Vit. D, Skimmed, Acidophilus, and Fresh Lo-Sodium Milks

MENIC™

C.N.S. stimulant

cerebral vasodilator

in the

senility syndrome

cerebral arteriosclerosis

and **mental confusion**

Each scored tablet contains pentylenetetrazole 100 mg. (1½ gr.) nicotinic acid 50 mg. (5/6 gr.) in bottles of 100 and 500 tablets. Usual dose: 2 MENIC tablets t.i.d., p.c.

Literature and samples available upon request.

MENIC combines the mutually enhancing action of the effective analeptic, pentylenetetrazole, with the proven cerebral vasodilator, nicotinic acid.

MENIC acts to increase oxygen and blood supply to the brain and so helps to overcome the cerebral ischemia and hypoxia responsible for many senility symptoms. Produced physical, mental and social improvement.[1] Menic makes possible a more comfortable, happier life.

1. Levy, S.: J A.M.A. 153:1260, 1953.

GERIATRIC

GERIATRIC PHARMACEUTICAL CORP.

BELLEROSE, L. I., N. Y.

Pioneers in Geriatric Research

Reduce pressure through bradycardic, tranquillizing action....

'Rauwistan'

the MRT-standardized Rauwolfia

BECAUSE its unique chemical and biological standardization assures uniformity and consistency of effect time after time with high activity and minimal incidence of side effects.

SUPPLIED: Tablets of 50 and 100 mg., in bottles of 100.

DOSAGE: 100 to 300 mg. daily, in divided doses.

Reduce pressure through bradycardic, tranquillizing plus direct hypotensive action....

'Verwolfia'

the MRT-standardized Rauwolfia-Veratrum

BECAUSE it adds to Rauwistan the specific hypotensive effect of uniquely standardized Veratrum and assures uniformity and consistency of effect time after time with high activity and minimal incidence of side effects.

SUPPLIED: 50 mg. of Rauwolfia serpentina and of Veratrum viride (standardized whole root) in each tablet; in bottles of 50 and 100.

DOSAGE: 1 to 3 tablets daily for the first 2 or 3 days; then 1 or 2 tablets daily, as required.

MRT *M.R. Thompson, Inc.* Cranford, N. J.

REPRESENTATIVE FUNERAL DIRECTORS

OF THE STATE OF NEW JERSEY

Special and Dependable Service Day and Night. Special Attention Given to Hospital Calls, Train and Express Shipments.

Place	Name and Address	Telephone
ADELPHIA	C. H. T. Clayton & Son	FReehold 8-0583
ASBURY PARK	Ely Funeral Home, 514 Second Ave.	PRospect 5-0567
ASBURY PARK	Matthews, Francioni & Taylor Funeral Home, 704 7th Ave.	PRospect 5-0021
ATLANTIC CITY	H. M. Gormley Funeral Home, 911 Pacific Ave.	ATlantic City 4-3188
BERGENFIELD	Riewerts Memorial Home, 187 S. Washington Ave.	DUmont 4-0700
BLOOMFIELD	George Van Tassel's Community Funeral Home	PIlgrim 3-1234
BOONTON	Lewis & Carey Incorporated, 312 W. Main St.	DEerfield 4-0842
CAMDEN	F. T. Walker & E. E. Walker Fun. Home, 743 Chestnut St.	WOodlawn 3-2581
CHATHAM	Wm. A. Bradley Funeral Home, 345 Main St.	MErcury 5-2428
COLLINGSWOOD	Schaffhauser Funeral Home, 983 Haddon Ave.	ULysses 4-5454
CRANBURY	A. S. Cole Son & Co., Main St.	EXport 5-0770
ELIZABETH	Aug. F. Schmidt & Son, 139 Westfield Ave.	ELizabeth 2-2268
ENGLEWOOD	Greenleaf Funeral Home, Inc., 108 W. Palisade Ave.	ENglewood 3-0416
FREEHOLD	Higgins Memorial Home, 20 Center St.	HOpkins 2-0895
HOBOKEN	Failla Memorial Home, 533 Willow Ave.	HOboken 3-0082
JERSEY CITY	Edward W. Bromirski Funeral Home, 221 Warren St.	HEnderson 4-4883
JERSEY CITY	Patrick J. Conte Funeral Home, 36 Tuers Ave.	HE 5-6451, DE 3-9259
JERSEY CITY	McLaughlin Funeral Home, 591 Jersey Ave.	OLdfield 3-2266
JERSEY CITY	Donald F. Wood Funeral Residence, 582 Bergen Ave.	DElaware 3-6480
LINDEN	Don McCracken Funeral Home, 2124 St. Georges Ave., E.	ELizabeth 2-3270
LITTLE FALLS	Norman A. Parker Funeral Home, 47 Main St.	CLifford 6-4700
METUCHEN	Runyon Mortuary, 568 Middlesex Ave.	LIberty 8-0149
MOORESTOWN	Harvey H. Brown Funeral Home, 10 W. Main St.	BElmont 5-5555
MORRISTOWN	Raymond A. Lanterman & Son, 126 South St.	JEfferson 9-2880
NEWARK	Barrish Funeral Home, 684 Clinton Ave.	ESsex 3-1551—9179
NEWARK	Beckett's Funeral Home, 120 W. Market St.	MItchell 2-4068
NEWARK	James E. Churchman Service, 132 Clinton Ave.	BIgelow 8-1672
NEWARK	Peoples Burial Co., 84 Broad St.	HUmboldt 2-0707
NEWFOUNDLAND	Stickle Funeral Home, Union Valley Road	OXbow 7-8141
PARAMUS	Vander Platt Memorial Home, S-113 Fairview Ave.	DIamond 2-3688
PATERSON	DeLuccia Funeral Home, 111 Belmont Ave.	LAmbert 3-6666
PATERSON	R. Charles D. Legg & Sons, 384 Broadway	SHerwood 2-2385
PATERSON	Moore's Home For Funerals, 384 Totowa Ave.	ARmory 8-1500
PATERSON	Scanlan Funeral Homes, 421 Twelfth Ave., at E. 28th St.	SHerwood 2-6433
PATERSON	Vermeulen Memorial Funeral Home, 131 Haledon Ave.	MUlberry 4-3974
POINT PLEASANT	George W. Whateley Funeral Home, 1105 Arnold Ave.	TWinbrook 9-0792
RAHWAY	Lehrer Funeral Home, 275 W. Milton Ave.	Fulton 8-1874
RAMSEY	The Harold Van Emburgh Funeral Home, Inc.	DAvis 7-0030
RIDGEWOOD	C. C. Van Emburgh, Inc., 306 E. Ridgewood Ave.	GIlbert 5-0344
RIVERDALE	George E. Richards, Newark Turnpike	TEmple 5-0164
SOUTH AMBOY	The Gundrum Service, 237 Bordentown Ave.	PArkway 1-0241
SOUTH RIVER	Rezem Funeral Home, 190 Main St.	SOuth River 6-1191
SPOTSWOOD	Hulse Funeral Home, 455 Main St.	SOuth River 6-3041
TRENTON	Daniel Brenna Funeral Home, 340 Hamilton Ave.	EXport 3-2857
TRENTON	Ivins & Taylor, Inc., 77 Prospect St.	EXport 4-5186
TRENTON	Elmer A. Kemp Funeral Home, 260 White Horse Ave.	EXport 4-5094
TRENTON	Poulson & Van Hise, 408 Bellevue Ave.	EXport 6-8168
TRENTON	Saul Funeral Homes	JUn. 7-8221—7-0170
WEST ENGLEWOOD	Clifford H. Peinecke Funeral Home, 1312 Teaneck Rd.	TEaneck 7-2332

for chronic bronchitis

Tetrex® capsules

The Original Tetracycline Phosphate Complex

U. S. PAT. NO. 2,721,609

effective control of pathogens...with an unsurpassed record of safety and tolerance

SUPPLY: TETREX Capsules – tetracycline phosphate complex – each equivalent to 250 mg. tetracycline HCl activity. Bottles of 16 and 100.

TETREX Syrup – tetracycline (ammonium polyphosphate buffered) syrup – equivalent to 125 mg. tetracycline HCl activity per 5 ml. teaspoonful. Bottles of 2 fl. oz. and 1 pint.

BRISTOL LABORATORIES, SYRACUSE, NEW YORK
Div. of Bristol-Myers Co.

BRISTOL ™

PRESCRIPTION PHARMACISTS

TO THE MEMBERS OF

The Medical Society of New Jersey

Place	Name and Address	Telephone
BELLEVILLE	Joralemon Pharmacy, 531 Joralemon St.	PLym'th 9-4535-9858
BERGENFIELD	Hart's Pharmacy, 475 So. Washington Ave.	DUmont 4-1119
BLOOMFIELD	Burgess Chemist, 56 Broad St.	PIlgrim 3-1005
BOONTON	Preston Drugs, Del's Village Shopping Center	DEerfield 4-3465
BOUND BROOK	Lloyd's Drug Store, 305 East Main St.	ELliot 6-0150
BUTLER	Fink's Pharmacy, 178 Main St.	BUtler 9-0090, 9-1063
CLOSTER	Mid Town Pharmacy, 237 Closter Dock Road	CLoster 5-0070
DUMONT	Lerrow's Pharmacy Inc., 10 W. Madison Ave.	DUmont 4-0842-1500
EDISON TOWNSHIP	Walter's Pharmacy, 1034 Amboy Ave.	LIberty 8-2614
EMERSON	Emerson Pharmacy, 201 Kinderkamack Road	COlfax 2-4999
FLEMINGTON	Green's Pharmacy, 52 Main St.	FLemington 108
FORDS	Fords Pharmacy, Inc., 550 New Brunswick Ave.	HIllcrest 2-4568
GLOUCESTER	King's Pharmacy, Broadway and Market Sts.	GLouc't'r 6-0781-8970
HIGHLANDS	Highlands Pharmacy, 148 Bay Ave.	HIghlands 3-1058
JERSEY CITY	The Cole Pharmacy, Inc., 710 Grand St.	DElaware 3-9294
JERSEY CITY	J. B. Feinberg Pharmacy, 659 Newark Ave.	OLdfield 3-6376
JERSEY CITY	Honiberg Drug & Surgical Supply Co., 618 Newark Ave.	SWarthmore 8-6700
JERSEY CITY	Lauria's Pharmacy, 768 West Side Ave.	HEnderson 3-1519
KEYPORT	Sav-On-Drugs, J. Meisler, opp. Post Office	COlfax 4-0904
MILLTOWN	Milltown Pharmacy, 21 No. Main St.	MIlltown 8-0081
MILLVILLE	Richard H. Knowles Pharmacy, 600 No. High St.	TAylor 5-0721
MOORESTOWN	Stiles' Pharmacy, 75 East Main St.	BElmont 5-0088
MORRISVILE, PA.	Pryor's Pharmacy, Bridge St. & Penna. Ave.	CYpress 5-7416
MOUNT HOLLY	Goldy's Pharmacy, Main & Washington Sts.	AMherst 7-3800
MOUNT HOLLY	Mount Holly Pharmacy, 64 Main St.	AMherst 7-0453
NEWARK	Giannotto's Pharmacy, 195 First Ave.	HUmboldt 2-8220
NEWARK	G. Maggio's Prescription Pharmacy, 136 Fleming Ave	MItchell 2-8915
NEWARK	Marquier's Pharmacy, Sanford & So. Orange Aves.	ESsex 3-7721

(Continued on following page)

PRESCRIPTION PHARMACISTS

TO THE MEMBERS OF

The Medical Society of New Jersey

(Continued from preceding page)

NEW BRUNSWICK	Bode Drug Co., 120 French St.	KIlmer 5-2676
NEW BRUNSWICK	Hoagland's Drug Store, 365 George St.	KIlmer 5-0048
NEW BRUNSWICK	Rutgers Pharmacy, 429 Livingston Ave.	CHarter 9-6666
NEW BRUNSWICK	Tobin's Drug Store, 335 George St.	CHarter 9-0780
NEW BRUNSWICK	Zajac's Pharmacy, 225 George St.	KIlmer 5-0582
OCEAN CITY	Selvagn's Pharmacy, 862 Asbury Ave.	OCean City 3535
PASSAIC	Wollman Pharmacy, 143 Prospect St.	PRescott 9-0081
PATERSON	Vallario's Pharmacy, 357 Totowa Ave.	ARmory 4-2139
PAULSBORO	Nastase's Pharmacy, 762 Delaware St.	PAulsboro 8-1569
PERTH AMBOY	Jacobs' Drug Store, 434 Amboy Ave.	VAlley 6-3273
PITMAN	Lodge's Pharmacy, 39 So. Broadway	LUther 9-2392
PRINCETON	The Thorne Pharmacy, 168 Nassau St.	WAlnut 4-0077
RAHWAY	Kirstein's Pharmacy, 74 East Cherry St.	RAhway 7-0235
RIDGEFIELD PARK	Lloyd's Prescriptions, 209 Main St.	DIamond 2-8383
RIDGEWOOD	Davis Pharmacy, Inc., 2 Wilsey Square	OLiver 2-2444
RIVER VALE	River Vale Pharmacy, River Vale Rd. cor. Westwood Ave.	NOrth 4-5553
RUMSON	Rumson Pharmacy, W. E. Fogelson	RUmson 1-1234
SOUTH AMBOY	Madura Pharmacy, 115 N. Broadway	PArkway 1-1732
SOUTH ORANGE	Taft's Pharmacy, 2 South Orange Ave.	SOuth Orange 2-0063
TRENTON	Adams & Sickles, State & Prospect Sts.	OWen 5-6396
TRENTON	Delahanty's Pharmacy, State St. at Chambers	EXport 3-4261
TRENTON	Episcopo's Pharmacy, Chambers & Liberty Sts.	EXport 3-3017
TRENTON	Foy's Drug Store, 3024 So. Broad St.	EXport 3-2367
TRENTON	H. S. Hughes, Thatcher Pharmacy, 401 Hudson St.	EXport 2-5616
TRENTON	Kehr's Pharmacy, A. F. Capriotti, R.P., M.P.A.	OWen 5-6807
TRENTON	Lee's Sun Ray Pharmacy, 940 Parkway Ave.	TUxedo 2-3456
UNION	Perkins Union Center Pharmacy	MUrdock 6-0877
UNION CITY	Husni's Pharmacy, 2503 Bergenline Ave.	UNion 5-2577
UNION CITY	Jos. Parentini's Pharmacy, Inc., Charles H. Arnoldi	UNion 7-4806
WEST NEW YORK	The Owl Pharmacy, 6611 Bergenline Ave.	UNion 5-0384
WEST ORANGE	West Orange Pharmacy, 443 Main St.	ORange 4-9824
WRIGHTSTOWN	Bowen's Pharmacy, 152 Fort Dix Road	RAymond 3-2176

for every phase of cough... comprehensive relief

AMBENYL® EXPECTORANT

MBENYL EXPECTORANT quickly comforts the oughing patient because it is formulated to elieve all phases of cough due to upper espiratory infections or allergies. Combining mbodryl®—potent antihistaminic; Benadryl®—e time-tested antihistaminic-antispasmodic; nd three well-recognized antitussive agents, MBENYL EXPECTORANT:

soothes irritation • quiets the cough reflex decongests nasal mucosa • facilitates expec-oration • decreases bronchial spasm • and astes good, too.

Each fluidounce of AMBENYL EXPECTORANT* contains:

Ambodryl® hydrochloride (bromodiphenhydramine hydrochloride, Parke-Davis)	24 mg.
Benadryl® hydrochloride (diphenhydramine hydrochloride, Parke-Davis)	56 mg.
Dihydrocodeinone bitartrate	1/6 gr.
Ammonium chloride	8 gr.
Potassium guaiacolsulfonate	8 gr.
Menthol	q.s.
Alcohol	5%

Supplied: Bottles of 16 ounces and 1 gallon.

Dosage: Every three or four hours—adults, 1 to 2 teaspoonfuls; children ½ to 1 teaspoonful. 27160

* Exempt narcotic

PARKE, DAVIS & COMPANY
Detroit 32, Michigan

PARKE-DAVIS

in overweight

To improve your patients' mood and to help them stick to their diets:

DEXAMYL® Spansule® capsules Tablets • Elixir

brand of dextro amphetamine and amobarbital

Each 'Dexamyl' Spansule sustained release capsule (No. 2) contains 'Dexedrine' (brand of dextro amphetamine sulfate), 15 mg., and amobarbital, 1½ gr. Each 'Dexamyl' Spansule capsule (No. 1) contains 'Dexedrine', 10 mg., and amobarbital, 1 gr.

To curb appetite and to restore energy when your patient is listless and lethargic:

DEXEDRINE® Spansule® capsules • Tablets • Elixir

brand of dextro amphetamine

Each 'Dexedrine' Spansule sustained release capsule contains dextro amphetamine sulfate, 5 mg., 10 mg., or 15 mg.

SMITH KLINE & FRENCH

The New York Academy of Medicine

DUE IN TWO WEEKS UNLESS RENEWED.
NOT RENEWABLE AFTER 6 WEEKS

DATE BORROWED	BORROWER